Management and Union Health and Medical Programs

U. S. DEPARTMENT OF
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MANAGEMENT AND UNION HEALTH AND MEDICAL PROGRAMS

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Foreword

IN recent years the negotiation of many types of health and welfare programs in collective bargaining contracts has brought to the attention of the general public the interest of management and labor in the field of employee health and medical care. This interest has been regarded by the public as a new development in labor relations—an extension from the traditional concern of managements and their employees with wages and hours and working conditions.

Close observers of the field of medical care as well as labor relations, however, have long been conscious that the interest of management and workers in health and medical care programs was not a new thing. Some companies and unions established programs of this type more than a hundred years before the surge of interest in voluntary health and welfare plans that came during World War II.

This volume is an effort to trace the origin and growth of health and medical care programs under management or employee sponsorship and to describe selected programs. It is the third in a series of studies produced by the Public Health Service dealing with the broad area of health and medical services in industry. It is hoped that it will be valuable not only to management and employee groups, but to other interested persons.

Leonard A. Scheele

Surgeon General,
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Preface

THIS volume is the third in a series on health and medical facilities in industry. The first two dealt largely with the facilities available to employees within their working environment, generally referred to as in-plant services. *Industrial Health and Medical Programs*, published in 1950, covered the broad field, and was followed two years later by the second volume, *Small Plant Health and Medical Programs*, in which problems peculiar to the small plant were presented.

Management and Union Health and Medical Programs presents the results of yet another exploration into the area of employee health, this time with emphasis on the provision of medical care outside of the plant, for the workers, and sometimes their families, under the sponsorship of employees' organizations or unions, or of management, or both.

The development of early programs is traced and mention made of the significant events which brought about the current practice of including health and welfare provisions under collective bargaining. Management and union sponsored health and medical programs have gone through several distinct phases. In the early years, many employee groups as well as management, alone or in cooperation with employees, sponsored health programs. Later, stimulated especially by wage control legislation, health and welfare programs were provided for employees in lieu of wage increases. Also discussed are the development of State workmen's compensation laws and their gradual extension to include coverage of occupational diseases.

The 10 health centers described in detail in this volume were selected as representative of plans providing different kinds of service. The inclusion of certain plans and the omission of others in no way imply a judgment as to the merits of either group.

Numerous questions concerning health plans have been raised by medical directors, company executives, trade-union leaders, insurance-company officials, and directors of voluntary health insurance programs. More specifically these questions dealt with the development of the programs, the kind and amount of benefits provided, methods of providing care, methods of administering and financing programs, and the relationship of these programs to other health services available to employed groups. This volume provides material useful in answering such questions.

This report is based on an analysis of published and unpublished material, correspondence, and personal interviews. Its preparation was made possible only through the generous cooperation of the medical directors of the health programs described and other authorities in the field of medical care, for which the authors are deeply appreciative. Grateful acknowledgement is made to Dr. William M. Gafafer, Mrs. Amy W. Firfer and Mr. Herbert Borchardt of the Division staff for their assistance. Appreciation also is expressed to Dr. William A. Sawyer, former medical director of Eastman Kodak Co., now medical consultant to the International Association of Machinists, for his critical review of the manuscript and for his constructive suggestions.

Seward E. Miller,
Medical Director,
Chief, Division of Occupational Health.

Organization of Material

This report is in five sections. The first presents information on the development of health and medical programs for employed groups. It describes the early efforts of employers and employees to provide services for both occupational and nonoccupational illnesses and the significant events which brought about the current practice of including health and welfare provisions under collective bargaining. It discusses, too, the development of State workmen's compensation laws and the gradual extension of the laws to include coverage of occupational diseases. The development of voluntary health insurance for employed groups is also traced.

Section II defines the extent to which employed groups have medical protection through management- and union-financed programs and the types of benefits provided.

The third section describes methods of providing benefits and the characteristics of insurance company, Blue Cross, and Blue Shield contracts under which most employees having insurance are now enrolled.

Section IV covers contract negotiations between management and labor for the provision of medical benefits and the various methods of financing and administering the benefits provided.

The fifth section describes in detail several programs, principally health centers, that have been developed to provide preventive and diagnostic services and in some instances treatment. Both the background and present status of these plans have been outlined.

Since detailed information is readily available on benefits provided through Blue Cross, Blue Shield, and insurance company contracts, only general and nationwide information of this specific type has been presented. References to the literature in this field, however, are included in the bibliography.

Appendixes contain detailed information that may be of assistance to persons interested in or responsible for the development and direction of employee health and medical programs. The material available has determined the detail in which information has been provided on the various programs.

The bibliography is restricted to general information in the field and does not include all references following the description of each of the programs included in section V.

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Section I

Development of Management and Union Programs

Early Industrial Plans

Management and labor have long had a common interest in employee health extending far beyond care for industrial injury and occupational disease. Earliest efforts by employers and employee groups to bring health services to employees and their families date back to the middle of the 19th century. During the latter part of the 19th and the 1st part of the 20th century, an increasing number of individual employers and small employee groups established medical care programs.

Lumbering, mining, railroading, and other hazardous industries, usually located in remote areas where medical facilities were not available, established the first prepaid medical care programs to care for employees and usually for their dependents. The programs were often jointly financed by employer and employees and in some instances grew out of employee organizations.

The factors which led to the establishment of the first prepayment plans also influenced the type of benefits they provided. Regardless of the method by which the programs were financed—whether by employers, by employees, or jointly—the majority of them offered such medical care as might be needed in the home as well as in the physician's office and in the hospital. Almost without exception, these programs served the employees of the one firm directly concerned with the program, and many times included service to the dependents of the employees. Physicians usually were employed on a full- or part-time basis. Some organizations owned their own hospital facilities, and a limited number included among their benefits visiting nurse service and dental care. Later on, medical services for workmen's compensation cases were frequently provided by the same medical staff, but not as part of the prepayment program.

Many of the early prepayment programs are still operating, their importance undiminished, but in the past 10 years they have been overshadowed by the expansion of employee health and medical care plans which have frequently assumed industry-wide and even nationwide proportions.

Examples of early medical care programs associated with industry follow:

1868—First major industrial medical care prepayment program that is still in existence—that of the Southern Pacific Railroad Co.—was organized in Sacramento, Calif. Other early railroad programs still in operation are the Missouri Pacific Hospital Association, established in 1872, and the Northern Pacific Beneficial Association, in 1882.

1887—The Homestake Mining Co. of Lead, S. Dak., established a company-financed medical department with full-time staff to provide complete medical service to its employees and their families.

1891—The employees of New York City gas companies affiliated with Consolidated Gas Co. of New York (predecessor of Consolidated Edison Co. of New York) to form a benefit program. The society engaged its own physician in 1906; in 1916, it opened the first of a number of dispensaries where members received treatment, or when necessary, arrangements were made for treatment at home; in 1922, dental services were added to the benefits. The company began to contribute to the program in 1902. The current collective bargaining agreement provides that management shall continue the existing program for the duration of the contract.

1897—The forerunner of the present Roanoke Rapids employees medical fund, covering the Patterson Mills, the Roanoke Mills, and the Rosemary Manufacturing Co. of Roanoke Rapids, N. C., was established under joint employer-employee sponsorship.

1913—The health department of the Tennessee Coal, Iron & Railroad Co. at Birmingham, Ala., was established to provide complete medical service to employees and their dependents through joint contributions from employees and employer.

1918—The workers medical and relief department of Endicott-Johnson Corp. of Johnson City, N. Y., was established to provide complete medical service to employees and their dependents at the expense of the company.

1924—The Stanocola Employees Medical and Hospital Association, Inc., Standard Oil Co. of Louisiana, was established to provide complete medical services to employees and their dependents under a program jointly financed by employer and employees.

Mutual Benefit Association and Union-Sponsored Health and Welfare Programs

Late in the 18th century, many groups of workers throughout the country organized mutual aid associations, such as loan, sick benefit, or burial societies. In effect, these programs were an outgrowth of the friendly societies developed earlier in England. One of the first organizations in this country was the Free African Society, a mutual benefit association formed in Philadelphia in 1787. Cash disability benefits, which replaced part of the income lost during illness, were the first health benefits provided, but medical service programs soon followed. Some of these associations extended their activities and assumed what today would be called "industrial functions," thus becoming forerunners of modern labor unions. Examples follow:

1806—The Pennsylvania Society of Journeyman Cabinetmakers of Philadelphia was established as a benevolent society; in 1829, the society set itself up constitutionally "as a criterion for workmen to endeavor to settle all disputes arising between them and their employers."

1810—The Philadelphia Typographical Society was incorporated as a benevolent society; it was reorganized in 1833 with its primary purpose described as "the determination and support of adequate wages for journeymen printers."

1859—The Iron Molders' Union was established; it operated an extensive benefit system before assuming industrial functions. All benefits were suspended

by the union in 1880 on grounds that such features interfered with industrial tasks of organization; they were resumed after ten years.

1873—The Brotherhood of Locomotive Firemen and Enginemen was formed as a benevolent society; in 1885, it assumed the role of labor union.

Carpenters, shoemakers, printers, and other crafts began to organize during the late 1700's, but these unions were confined to local areas and were usually weak because they seldom included a large proportion of workers. Most of them existed for only a short time, but many characteristic union techniques were first developed in this period. From the beginning, health and welfare benefits were a recognized part of union programs. Over a hundred years later, union leaders seeking to organize mass production industries found that many members of local unions were reluctant to join unless they were promised health, welfare, and other benefits which the smaller unions were providing. Among the early unions providing benefits were the following:

1877—The Granite Cutters' Union established the first of national union sick benefit programs.

1887—The Barbers' Union was established; a sick benefit system was organized in 1895.

1889—The Plumbers' Union was established; a sick benefit program began in 1903.

1895—The Tobacco Workers' Union was organized; a sick benefit program established in 1896.

1913—The New York locals of the International Ladies' Garment Workers' Union started the first union-sponsored service type of medical care plan; the union health center was incorporated in 1917.

Workmen's Compensation and Temporary Disability Laws

Since 1948, some form of workmen's compensation legislation has been in force in every State. The first laws were enacted in the early 1900's and covered accidents only. Gradually, their scope has been extended, and laws now in effect also cover all, or at least specified, occupational diseases. By January 1952, legislation in all but four States provided for some form of occupational disease coverage, and over 50 percent of the States provided full coverage. (See appendix 1.)

In 1951, workmen's compensation benefit payments were estimated to be $707 million, or 15 percent above the 1950 total, the payments reflecting both high wages in recent years on which compensation payments are based and the increased costs of hospitalization and medical services. Of the estimated $707 million, 63 percent was paid by private insurance carriers; 24 percent by State funds; and the balance, by self-insurers.

Workmen's compensation laws have had a decided influence on the development of both inplant preventive health programs and prepaid medical care plans which provide benefits during nonindustrial illnesses. Temporary disability benefit laws, which provide cash benefits during nonindustrial illnesses, undoubtedly will also stimulate the development of preventive health services. These laws have now been enacted in 4 States and similar legislation has been under consideration in at least 20 others.

Significant events relating to workmen's compensation and temporary disability legislation were as follows:

1906—Montana passed a law providing for State cooperative insurance funds for workers in and around coal mines; the law was declared unconstitutional in 1911.

1908—Congress enacted a law granting to certain employees of the United States the right to compensation for injuries sustained in the course of employment; in 1916, it replaced this law with one covering all Federal civilian employees.

1910—New York State enacted 2 workmen's compensation laws—1 compulsory, 1 voluntary; the compulsory law was held invalid by the New York Court of Appeals in 1911; an amendment to the State constitution made possible the enactment of a compulsory law in 1914.

1911—State of Washington passed the first effective compulsory workmen's compensation law. New Jersey passed the first elective type of workmen's compensation law with certain penalties attached for non-election. Eight other States enacted laws during the same year—California, Illinois, Kansas, Massachusetts, Nevada, New Hampshire, Ohio, and Wisconsin.

1917—Hawaii enacted the first legislation covering occupational disease. Occupational disease legislation was enacted in California in 1918, and in Connecticut and Wisconsin in 1919.

1942—First State temporary disability benefit law was passed in Rhode Island. Other State laws were passed in California in 1946, in New Jersey in 1948, and in New York in 1950.

1948—Mississippi was the last State to adopt workmen's compensation.

1951—State of Nevada enacted legislation providing for rebates in workmen's compensation insurance premiums up to 20 percent, or twice the previous rate, to any plant maintaining for 2 years a "high standard of safety or accident prevention as to differentiate it from other like establishments or plants." Rebates up to 30 percent, or twice the former rate, are specified for plants which maintain such standards for more than 2 years.

Health Benefits Under Collective Bargaining

Both unions and industry have developed their most distinctive features and have had their greatest growth since 1900, during an era of great economic, social, political, military, and scientific changes. By the end of the 19th century, mass production and mechanization were being applied to some industries, but, with a few possible exceptions, the large, nationwide, highly mechanized industries have been

products of the last 50 years. By 1900, a number of unions were operating, but the large national and international unions had not yet taken their place in the economic life of the United States. Information on the growth and distribution of the labor force and union membership (appendixes 2–7) indicates the vast changes that have taken place since the turn of the century.

Although union interest in health and welfare benefits is as old as the unions themselves, the practice of including such benefits under collective bargaining agreements is a recent development.

Events influencing this trend include the following:

1918—The War Labor Board, established during World War I, recognized the right of workers to organize trade unions and bargain collectively, as well as the right of employers to organize associations for bargaining purposes. General principles under which the Board operated were significant as a reflection of a new governmental attitude toward labor.

1926—Congress enacted the first Railway Labor Act which included many of the principles developed by the War Labor Board.

The Public Service Corp. of Newburg, N. Y., and the Amalgamated Association of Street and Electric Railway Employees adopted the first collective bargaining agreement containing a health and welfare clause. It provided for life insurance and weekly cash benefits.

1935—The National Labor Relations Act set up the National Labor Relations Board and recognized the rights of workers to organize and bargain collectively with employers through representatives of their own choosing.

1942–45—The National War Labor Board was established to determine procedures for settling disputes. Board laid down the "Little Steel" formula for wartime wage adjustments based on a 15 percent rise in living costs from January 1, 1941, to May 1, 1942. With wage increases blocked, "fringe issues" assumed importance. The War Labor Board originated the term "fringe issues" to decide what it defined as "miscellaneous adjustments, mainly related to working conditions, which directly or indirectly affect employees' compensation and which are normally designed to meet a special situation or problem within a company or industry." Favorable policy toward "fringe issues" adopted by the War Labor Board, as well as a ruling of the Bureau of Internal Revenue that, for income tax purposes, money advanced by employers toward legitimate insurance plans for employees could be deducted from gross income as a proper business expense, stimulated the growth of union health and welfare programs under collective bargaining.

1946—The Krug-Lewis agreement established health and pension funds in the bituminous coal industry.

1947—The Labor Management Relations Act, 1947 (Taft-Hartley Act), was passed, requiring that funds appropriated for health programs (and other specified programs) be administered by boards with equal representation from union and management.

1948—In April, the National Labor Relations Board held in the Inland Steel case that pension and insurance benefits were included in the terms "wages" and "conditions of employment" under the Wagner and Taft-Hartley Acts. Employers were, therefore, under statutory obligations to bargain with the employee representatives concerning the terms of a retirement program. In June, the Board also ruled that employers were required to bargain over pensions and a group insurance plan and, in addition, that

they could not institute a group insurance plan without consulting the statutory bargaining representatives. Subsequent ruling by Board and courts upheld this decision.

1949—The Presidential Board of Inquiry, investigating a labor dispute in the basic steel industry, concluded that "industry, in the absence of adequate Government programs, owes an obligation to the workers to provide for maintenance of the human body in the form of medical and similar benefits and full depreciation in the form of old-age retirement—in the same way as it does now for plant and machinery. This obligation is one which should be fulfilled by enlightened business management, not when everything else has been taken care of but as one of the fixed costs of doing business—one of the first charges before profits."

1951—Health program provisons in labor-management agreements were accelerated by regulations of the Wage Stabilization Board, which ruled that the inclusion of health and welfare benefits under collective bargaining was not in conflict with objectives of the Defense Production Act.

Growth of Voluntary Health Insurance

The growth of voluntary health insurance has coincided with the growth of health and welfare programs under collective bargaining agreements. During the 10-year period, 1942–52, hospital coverage increased from about 20 million persons to more than 92 million, and surgical coverage, from about 8 to 73 million. The number of persons eligible for some form of medical care, principally for hospitalized illnesses, also increased greatly during this period—from 3 million persons in 1942 to 36 million in 1952. The growth of these three types of coverage during and after the war is shown in figure 1.

Coverage varies considerably by State (appendix 8). In States with the higher per capita income and the larger proportion of their population living in urban centers more of the people are insured against the cost of hospital, surgical, and medical care.

The growth of each of the three types of voluntary health insurance is shown by the fact that enrollment at the end of 1952 represented the following increases over enrollment 2 years earlier:

	Percent
Hospitalization	19
Surgical coverage	34
Medical care	65

The 92 million persons in the United States estimated to be eligible for hospitalization at the close of 1952 represented about 59 percent of the civilian population; surgical and medical coverage had been extended to 47 and 23 percent, respectively. With the exception of approximately 5 million persons enrolled in several other types of programs, the entire coverage was under Blue Cross, medical society, and insurance company contracts. Distribution was as follows:

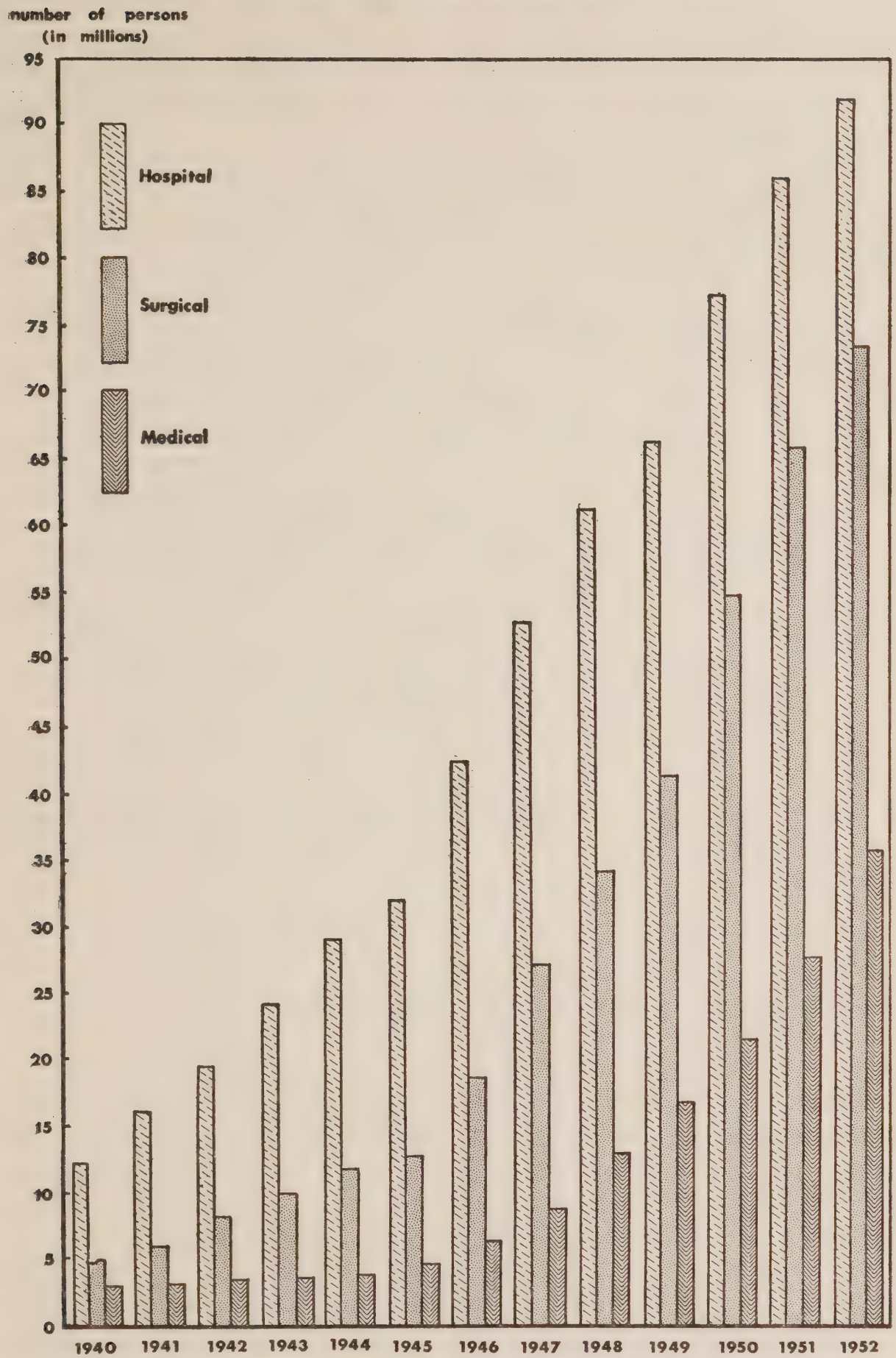

Figure 1.—Growth in hospital, surgical, and medical expense coverage by years, 1940–52

Source: The Survey Committee of the Health Insurance Council: *A Survey of Accident and Health Coverage in the United States.* New York, The Council, 1953.

Item	Hospital	Surgical	Medical
Persons covered:			
Grand total	100, 548, 000	81, 384, 000	38, 746, 000
Deduction for estimated duplication	8, 881, 000	8, 223, 000	2, 949, 000
Net total	91, 667, 000	73, 161, 000	35, 797, 000
Percent (of grand total), enrolled under:			
Insurance contracts	52	60	40
Blue Cross and medical-society sponsored plans [1]	43	34	47
Other	5	6	13

[1] With few exceptions, Blue Cross plans do not provide medical or surgical coverage and medical society plans do not cover hospitalization.

Details as of the end of 1952 on the coverage of subscribers and dependents under individual and group insurance company contracts, under Blue Cross plans and plans sponsored by medical societies, and under industrial and other types of programs are given in appendix 9.

Voluntary health insurance is based on the principle of group coverage. Although, as a result of operating experience, the programs have been able to liberalize their policy regarding individual membership, group enrollment remains the core around which the programs are built. Since industrial workers and their dependents are the most numerous and accessible groups, the membership in these programs is predominantly among employed groups. Union members and their dependents alone represent a substantial part of the membership in Blue Cross, Blue Shield, and insurance company plans.

The proportion of persons having hospital insurance has been found to be twice as high per unit of population in urban as in rural States. A similar ratio between high- and low-income States also indicates that the bulk of the coverage is in areas where there are steadily employed moderate- or high-income groups.

Insurance Company Contracts

The first health insurance contracts offered by insurance companies covered accidents only. Sickness insurance began to develop about 1890. The first policies provided very limited benefits and partially reimbursed patients for time lost from work during disability. During the early 1900's, some insurance companies extended their contracts to cover weekly indemnity payments for hospital and surgical care. Today, health-insurance contracts may be purchased by both individuals and groups. Insurance companies and associations issuing health and accident protection include nearly every type of insurance organization—health and accident companies, life-insurance companies, casualty companies, fire-insurance companies, and various fraternal societies and other organizations.

Significant events included:

1911—First group insurance contracts were written. Life insurance was the first type of benefit to be offered by companies and received widespread acceptance.

1914—First group insurance contracts for temporary disability benefits were written.

1918—The National Convention of Insurance Commissioners, which was composed of representatives of State insurance regulatory bodies, adopted a definition of group insurance and laid down certain basic principles to guide its development. Most life-insurance companies accepted the definition and principle immediately, and laws incorporating these provisions were passed in many States.

1935–37—Large life-insurance companies began to write group hospital expense insurance. At first, contracts were not sold separately but were written to supplement group life and disability contracts already in force. They covered employees only.

1936–38—Companies began to write surgical expense contracts and to cover dependents.

1940—Experiments in medical expense coverage began about this time; the practice became more general by mid-1940's.

1946—The Health Insurance Council was established primarily to provide insurance companies with a means of communicating with doctors, hospitals, and their organizations. The council is composed of representatives of nine insurance company associations.

1950—Companies began to write major medical expense contracts covering long-term expensive illnesses. The insured pays initial cost of illness up to a specified amount, varying according to cost of policy.

Blue Cross Hospital Plans

The first prepayment hospital service plans were developed by individual hospitals. Hospitals in northern Minnesota sold such insurance to lumberjacks as early as 1880. These early plans were successful at first, but they failed eventually because of overutilization.

The predecessor of the present Blue Cross plans was a hospital program established at Baylor University, Dallas, Tex., in 1929. The vice president of the university developed a plan at the request of teachers in the community. For a prepayment fee of $3 per semester or $6 a year, members were eligible for 3 weeks' hospitalization. Other employed groups in the city asked permission to join. Similar programs began to spring up in other sections of the country. Hospitals serving these communities soon realized the advantage of developing community-wide programs instead of operating individual hospital plans. By 1941, 65 approved hospital service plans, with an enrollment of more than 6 million persons, were in operation in the United States.

The following events were significant in the development of hospital plans:

1932—The first citywide plan was offered by hospitals of Sacramento, Calif. Plan developed out of an effort by one hospital in the city to provide hospital insurance for its own employees. Other hospitals asked to participate; later the general public was allowed to participate. The plan was set up as a mutual insurance company, and initial capital was supplied by the hospital.

In the fall of 1932, the council on community relations and administrative practice of the American Hospital Association appointed a consultant on group hospitalization.

1933—At the request of a small group of business men, a plan was started in Newark, N. J., in January. In 1937, this plan became the Hospital Service Plan of New Jersey.

Eight hospitals in St. Paul, Minn., began a program which later became the Minnesota Hospital Service Association. During the early years of its operation, the plan developed the idea of a Blue Cross symbol. Other programs started in 1933 in Durham, N. C.; San Jose, Calif.; and two in West Virginia. The San Jose and West Virginia plans later were discontinued or merged with other plans.

In February of 1933, the board of trustees of the American Hospital Association adopted a resolution approving the principle of hospital insurance and referred the subject to the council on community relations and administrative practice for study and recommendations. The Association also published a small publication, *Essentials of an Acceptance Plan for Group Hospitalization*, during the same year.

1934—The Hospital Service Association of New Orleans was started in February; it took over certain contracts of Touro Infirmary, which had initiated a program in 1932.

A plan was also started in Washington, D. C., with initial capital provided by the Community Chest; and in Cleveland, Ohio, were the Cleveland Hospital Council sponsored the program and funds were lent by Cleveland Welfare Federation.

1935—New York passed the first enabling legislation exempting plans from ordinary insurance regulations. Legislation was necessary because the State superintendent of insurance was the first authority to rule that proposed hospital service plans were engaging in insurance.

Nine plans were organized during this year—three in New York State, two in Virginia, and one each in Delaware, North Carolina, Pennsylvania, and Tennessee.

1937—The Commission on Hospital Service was organized. Originally, it was called the Committee on Hospital Service; in January 1946, it became the Blue Cross Commission.

Executives of nonprofit hospital service plans met in Chicago and announcement was made that the American Hospital Association authorized associate institutional membership. The outgrowth of this meeting was an approval program, initiated in 1948, permitting use of Blue Cross name and symbol for nonprofit hospital service plans.

1949—Health Services, Inc., was authorized. It provides means of enrollment through which uniform rates, benefits, and payments are provided for organizations with national coverage. First national contract was issued on November 1, 1950, to certain employees of the United Press Association.

1950—Nationwide agreements were made by the United Steelworkers of America and various steel companies in cooperation with local Blue Cross plans, providing all eligible workers of a company with uniform hospitalization benefits at uniform rates.

1951—The revised Inter-Plan Transfer Agreement became effective, superseding a 1949 agreement which most plans had observed to some extent. The revised agreement was developed to meet the need for uniform regulations regarding transfer of members. It is administered by Blue Cross Commission through a Transfer Board appointed annually.

Medical Society Sponsored Plans

The first prepayment medical society sponsored plans were organized by county medical societies which sought various methods of helping low-income families in the community meet the cost of illness. During the 1930's, local medical societies in Washington and Oregon contracted with employers to provide medical service for employees; the programs later expanded into prepayment plans with eligibility for enrollment on a broader basis. During the 1940's, medical societies in most States began to sponsor medical society programs.

The following significant events influenced the development of these plans:

1939—The first State medical society sponsored plans were established in California and Michigan. In the same year, Connecticut, New York, Pennsylvania, and Vermont enacted enabling legislation.

1940—Medical society plans were established in Buffalo and Utica, N. Y., in Pennsylvania, and in North Carolina.

1943—Approximately 1,000,000 persons were then enrolled in medical society sponsored plans. The house of delegates of the American Medical Association created the council on medical service to facilitate the exchange of data and to provide accurate information to everyone on the development of plans affecting the distribution of medical care.

1946—The Associated Medical Care Plans, Inc., was formed under the sponsorship of the American Medical Association as central agency for approving programs and coordinating their activities. Plans meeting council's standards are now known as Blue Shield plans.

1951—One or more plans were in operation in 48 States, the District of Columbia, and Hawaii.

Section II

Extent of Union Programs and Types of Benefits

Growth of Programs

A United States Department of Labor study shows that by mid-1950 practically every major union in the country (excluding unions representing railroad and government employees for whom special Federal, State, or municipal legislation exists) had to some extent negotiated pension or health and welfare programs, providing one or more of the following: life insurance or death benefits; accidental death and dismemberment payments; accident and sickness benefits (but not sick leave or workmen's compensation); cash or services covering hospital, surgical, maternity, and medical care.

The rapid growth of such programs is shown by the fact that the number of persons covered had more than doubled between 1948 and 1950. In the latter year, at least 7.7 million workers (about 50 percent of all union membership) were estimated to be eligible for some type of health, welfare, and/or pension benefit. At that time 4.6 million workers were eligible for health and welfare as well as pension or retirement benefits; 2.5 million, for health and welfare benefits alone; and 0.5 million, for pensions alone.

Differences in benefits provided were found to exist between the unions affiliated with the two major labor groups. Of 2.7 million AFL members reported to be covered by some kind of employee benefit plan under collective bargaining agreements in 1950, about a third had both health and welfare benefits and pensions, about half had health and welfare benefits alone, and about a sixth had only pensions. On the other hand, of the 3.6 million CIO members with coverage, more than three-fourths were covered by both types of benefits; about one fifth had only health and welfare benefits; and a very small proportion had pensions only. A pattern somewhat similar to that of the CIO was evident for the 1.3 million covered members of unaffiliated unions. In appendix 10, covered workers are classified according to type of benefit and union affiliation.

Of the more than 7 million workers eligible for health and welfare benefits, 4.8 million were estimated to have hospitalization, and 4.4, some type of medical coverage. In addition, an unknown number of dependents were eligible for hospitalization and medical benefits through such programs.

Current coverage for health and welfare benefits is estimated to be between 9 and 10 million (about two-thirds of all union membership), with 7 million estimated to have hospitalization and 6.5 million, some form of medical protection. Growth of the programs was greatly stimulated by relaxation of Wage Stabilization Board regulations in 1951 to permit inauguration or amendment of approved health and welfare plans without the necessity of including funds used for this

purpose in the 10 percent permissible increase in worker's compensation.

Information is not available on the duration of the collective bargaining agreements that include the various types of health and welfare benefits, an item of great importance to persons planning programs, but a recent report of the Bureau of Labor Statistics shows the prevalence of long-term agreements.[1] A listing of 177 significant current agreements, each involving more than 5,000 workers, indicates that approximately three-fourths were negotiated for a term exceeding 1 year, and almost 60 percent were to cover a period of two years or longer. Almost a million workers are covered by the 25 agreements with a term of 4 years or more.

The typical agreement with a duration of 2 years or more provides for automatic wage adjustments or for a reopening of the contract by either party on wage issues. The 177 agreements by duration are shown in the accompanying table.

Term	Number of agreements	Number of workers covered	Term	Number of agreements	Number of workers covered
Total	177	5,523,050	Over 3 and less than 4 years	3	56,000
1 year or less	45	1,193,650	4 years	2	23,600
Over 1 and less than 2 years	28	776,000	Over 4 and less than 5 years	10	508,000
2 years	40	545,400	5 years	10	436,700
Over 2 and less than 3 years	12	1,423,300	Over 5 years	3	18,000
3 years	20	437,700	Information not available	4	104,700

Coverage By Size of Industry

An analysis of 9,000 labor-management agreements (with and without health and welfare clauses) on file with the Bureau of Labor Statistics, United States Department of Labor, at the end of 1950, shows a great concentration of workers under agreements covering large groups. Although more than three-fourths of the 9,000 agreements covered less than 500 workers, less than one-sixth of the 7,000,000 covered workers came under these small agreements. As the following table indicates, more than three-fourths of the workers were under agreements covering 1,000 or more workers:

Agreement coverage	Percentage distribution	
	Number of agreements	Workers covered
Total	100.0	100.0
1–49	24.4	.9
50–499	53.2	12.5
500–999	10.6	9.1
1,000 and over	11.8	77.5

[1] U. S. Department of Labor, Bureau of Labor Statistics, *Collective Bargaining Agreements: Expiration Reopening, and Wage Adjustment Provisions of Major Agreements, BLS Report No. 17.* Washington, The Department, June 1953.

About 50 percent of the 7,000,000 workers were under contracts each covering 5,000 or more workers and negotiated with large employers or employer associations. In fact, 11 agreements, each covering 50,000 or more workers, accounted for about one-fifth of the total coverage under the 9,000 agreements. Among the contracts studied were 499 classified as "interstate." Many of the largest contracts fell into this category. Additional information from the study is given in appendix 11.

A comparison of workers under these 9,000 agreements with workers in units reporting to the Bureau of Old-Age and Survivors Insurance during approximately the same period, further illustrates the concentration of workers under agreements covering large numbers.

Size of worker group	Number of workers covered (in thousands)		Percent of old-age and survivors insurance coverage under agreements [1]
	Units reporting to old-age and survivors insurance	9,000 agreements	
Total	35,805	7,180	20.0
1–49	14,219	49	.3
50–499	11,085	912	8.2
500–999	3,012	651	21.6
1,000 and over	7,489	5,568	74.3

[1] With few exceptions workers covered by agreements were in units reporting to old-age and survivors insurance.

Although the workers covered by these 9,000 agreements represent only about 50 percent of all union members, most of whom are under some form of bargaining contract, the comparison seems worthwhile. If all or most of the other union members were under contracts with less than 1,000 workers, the predominance of coverage among workers in large groups would still be evident.

The results of a survey of personnel practices in the Cleveland, Ohio, area indicate that collective bargaining issues tend to vary with company size. The study is considered significant because the industry of Cleveland is diversified and union activities there are considered typical of such activities throughout the country. The study shows that labor has placed great emphasis on employee group insurance, but that the type of insurance a company has is governed almost completely by its size and financial ability to pay. Employees of small companies had less chance of being covered by an insurance plan than those working for a big manufacturer, but a large number of firms in all groups had instituted insurance programs for their employees, and in companies of more than 500 employees it was found to be almost standard policy. The average insurance program provided in 1950, the time of the survey, was described as follows:

Employee *A* working for a plant of less than 100 persons, if he enjoys insurance protection, can expect $1,000 in life insurance; sickness and accident benefits for 13 weeks; a surgical maximum of $150, and hospitalization for 31 days. The benefits to Employee *B*, whose job is in a plant of from 100 to 500 people, are about the same. Neither is covered by a pension plan. But Employees *C* and *D*, in companies having more than 500 workers, may get up to $2,000 life insurance, and a surgical maximum of $200, although the standard even in these cases is $150. Naturally, hospitalization and sickness and accident benefits are similar in all company size groups.[1]

Coverage By Major Industry Groups and Labor Markets

In 1950, more than two-thirds of the 7.7 million workers eligible for health, welfare and/or pension benefits under bargaining agreements were employed in three major industry groups. The number of workers covered in these three industries and the types of benefits for which they were eligible were as follows:

Industry group	Number of workers (thousands)	Percent eligible for—		
		Health, welfare and pensions	Health and welfare only	Pensions only
Metal products (including steel, and automobile and machinery	2,481	74.8	18.9	6.3
Textile, apparel, and leather	1,401	46.7	53.2	.1
Transportation, communication and other public utilities (excluding railroads	1,389	63.7	26.3	10.2

In all but one industry group, 90 percent or more of the workers were eligible for health and welfare benefits either alone or in combination with pensions. Additional information on the distribution of covered workers by industry group is included in appendix 12.

In most parts of the United States, the percentage of plant workers covered by health insurance and hospitalization benefits is higher in manufacturing establishments than in other types of employment. For pensions there is less difference between the manufacturing and other industry groups. The proportion of workers in manufacturing establishments with formal provision for sick leave is extremely low in all sections of the country.

A more recent survey, in 40 labor markets, of variously employed persons, most of whom were under collective bargaining agreements, brought to light substantial differences in types of coverage according to type of employment. The percentage of workers in different types of employment and in specified locations who are eligible for health

[1] Capes, Hubbard: Personnel Practices as Related to Company Size. *Personnel*, 27: 113–123 (September) 1950.

insurance follow. Additional information for other areas as well as similar information for hospitalization and paid sick leave is given in appendixes 13 to 15:

Type of benefit and area	Percent of plant workers covered for health insurance					
	All industries	Manufacturers	Public utilities	Wholesale trade	Retail trade	Services
Atlanta	57.4	68.1	63.3	42.7	48.3	33.5
Birmingham	48.8	57.5	60.8	25.7	31.4	5.6
Boston	75.5	84.1	77.8	52.4	69.7	54.1
Chicago	83.1	89.9	89.5	55.2	64.2	59.3
New York City	67.6	69.9	75.4	50.0	62.0	57.2
Philadelphia	63.9	76.0	40.2	28.6	59.0	24.4
Pittsburgh	79.3	89.4	72.5	42.7	30.3	54.3

In 6 of these 7 areas approximately two-thirds or more of the workers in manufacturing and public utilities had health insurance coverage; for the wholesale trade, retail trade, and service groups, the percentages were with few exceptions much lower in each area.

The predominance of health insurance and hospital benefits among manufacturing groups is not new. A study made in 1946 showed that 40 percent or more of the workers in most manufacturing industries were already under some type of bargaining agreement. A large number of manufacturing groups reported 80 to 100 percent coverage. For nonmanufacturing groups, a much smaller proportion of the industries reported high coverage. (See appendixes 16 and 17.)

The survey of 40 major labor markets, previously referred to (appendixes 13 to 15), showed that more than three-fourths of the areas had 50 percent or more of the plant workers in all industries eligible for health insurance and for hospitalization. The proportion of workers having sick leave and private pension coverage was much smaller.

The proportion of workers eligible for benefits varied according to region as well as according to markets within each region. The following table shows the distribution of the 40 markets according to region and the number of markets having a specified proportion of workers covered by health insurance and hospital benefits:

Region	Number of markets reporting	Number of markets with specified proportion of workers covered					
		Health insurance			Hospitalization		
		Less than 50 percent	50–75 percent	75 percent and over	Less than 50 percent	50–75 percent	75 percent and over
New England	4	0	3	1	0	4	0
Middle Atlantic	10	0	8	2	2	8	0
South	9	6	3	0	4	5	0
Middle West	11	0	6	5	1	9	1
Far West	6	2	4	0	2	4	0

The proportion of workers with paid sick leave provisions was extremely low in all markets. Only three markets reported more than 20 percent of workers with this type of benefit. All of them were in the Far West: San Francisco-Oakland, 27 percent; Salt Lake City, 25 percent; and Los Angeles, 21 percent.

Hospital, Surgical, and Related Benefits

Studies of health and welfare programs under collective bargaining indicate that workers formerly covered by only one or two benefits have in many cases had both the amount and type of their benefits extended. This trend was quite evident by mid-1950, when an analysis of benefits available to 4.3 million members in 140 unions showed that about three-fourths of the members were eligible for hospitalization and an almost equal number, for surgical and/or medical care. In addition, 96 percent of them had life insurance; 64 percent, cash sickness benefits; and 46 percent, accidental death and dismemberment coverage. Appendix 18 provides additional information from this study.

Since 1950, benefits have continued to grow, and have been greatly influenced by two factors—the Wage Stabilization Board policy with regard to health and welfare programs, and the increasing cost of hospital and medical care.

As a result of an analysis of plans now in effect in 67 corporations—all of them underwritten by insurance companies and 18 of them incorporated in union agreements—the National Industrial Conference Board reports that a strong trend toward raising group hospital, surgical, and medical benefits is seen when 1953 benefits are compared with those of 1949; new types of benefits have also been added; and coverage has been extended to employees' dependents. The statement is based on a comparison of current information with the results of an earlier study by the Board.

With regard to hospital benefits, the National Industrial Conference Board reports that in 1949 one-third of the plans with uniform benefits for all employees provided a daily hospital benefit of less than $5. All of the recently surveyed plans paid $5 a day or more, with 55 allowing $8 or more. Allowances for incidental hospital expenses have also been liberalized.

A study of the hospital benefits now provided by the corporations covered in the recent survey shows that 40 percent of the 67 plans permit a maximum duration of 70 days or more hospitalization for the employee. However, the most common allowance, as granted by 35 of the plans, is 31 days. Half of the plans allow at least 15 times the daily benefit for incidental hospital expenses, with a few going

considerably higher—100 times in 1 plan. Here again, however, a lower amount—10 times the daily benefit—was the most common figure, and was paid by 18 of the 67 plans. Further information on the amount and duration of hospital benefits and the allowance for incidental expenses is given in appendixes 19–21.

In 1949, the maximum surgical benefit allowed by approximately 80 percent of the plans was $150; in contrast, about 70 percent of the recently studied plans reported their maximum surgical benefit as $200 or more (appendix 22).

An analysis of 8 companywide hospital-surgical-medical plans, 4 entirely financed under collective bargaining and 4 jointly financed by employer and employee, was included in the National Industrial Conference Board's report. Hospital benefits for the employee were found to average $10 a day for a maximum of 31 days in most plans, with dependents also covered in all cases, although with a slightly lower daily allowance. Widely varying amounts were allowed for miscellaneous hospital expenses, the range extending from a flat $40 in one plan to $300 plus $25 for X-ray in another. The maximum surgical benefit, on the other hand, was usually $225 for both the employee and his dependents. Maternity benefits ranged from none in one plan to $14 a day for 14 days, plus $200 miscellaneous charges, plus $225 obstetrical fee. The main provisions of these eight programs are given in appendix 23.

Other sources of information on health and welfare programs bear out the Board's statement relative to increased benefits. For example, the New York City Building Trades reports a number of major changes in benefits available to more than 70,000 members of 28 union groups during 1950 and 1951 (appendix 24). Although there was considerable variation among the groups in benefit coverage, by January 1952, most of them had hospitalization, medical and/or surgical coverage, life insurance, accidental death and dismemberment benefits, and sickness and accident benefits.

Hospitalization insurance for these building trade workers ranged from $5 to $10 a day, with the higher figure being more common; the maximum number of days was usually 31. Nine of the groups had Blue Cross coverage, permitting 21 days in a semiprivate room and paying 50 percent of the charge for an additional 180 days. Twenty-four of the groups had surgical benefits, the maximum amount averaging slightly more than $200, and nine had medical coverage as well. Further information on the benefits available to the New York building trades workers is given in appendixes 25 to 27.

The average life insurance benefit for the groups was $1,000, although one group had a $150 benefit and another $3,000. The most common payment for accidental death and dismemberment was $1,000. Of the 24 groups reporting accident and sickness benefits, $26

a week for 13 weeks' duration was the usual payment allowed. Payment normally began on the eighth day for sickness; for accidents, payments more often began on the first day.

Another study, conducted in 1952, gives other recent data on the extent of coverage and type of benefits in one major city. It encompassed 64 health and welfare plans negotiated under collective bargaining by unions affiliated with the San Francisco Labor Council, AFL, and it indicated that approximately 88,500 workers, representing about half of the council's membership, are covered by some type of plan. Coverage is provided by 24 different commercial companies and service agencies. All 64 of the plans provide for health insurance (defined to include hospital, surgical, medical, and related health benefits). In addition, 55,763 members, or 63 percent of the total, are covered by life insurance, and 47,020, or 53 percent, by accidental death and dismemberment coverage. In 16 cases, automatic coverage for dependents is provided in the basic plan, and in 38 others, coverage for dependents is voluntary at the employee's expense. Additional data on the San Francisco survey may be found in appendix 28.

Health Benefits for the Older Worker and the Permanently Disabled

Officials of prepayment programs of all types are now giving greater consideration to the health problems of the permanently disabled as well as the older worker. Many workers who retire at 65 or some other fixed retirement age face the prospect of increasing medical costs without health insurance protection. The Health Information Foundation recently stated that the inclusion of our aged in the voluntary health insurance movement has real possibilities as an economic boon to the individual and his family and as a means of realizing more effective utilization of health services and facilities for the benefit of the entire community.[1]

A major difficulty in continuing health benefits for older workers is that they are denied coverage in some plans when they reach a designated age (usually 65), presumably because of fear of excessive demand for services. The Health Insurance Plan of Greater New York, which from the beginning has had no age barriers for admission or for retention of coverage, has found through experience, however, that the combination of prepayment, group enrollment, family coverage, group medical practice, and capitation payment of the medical groups, if carefully worked out, permits the inclusion

[1] *Progress in Health Services,* Health Information Foundation, July 1953.

of the aged in their proper proportions without undue risk to the premium rate structure of the plan.[1]

According to a recent report Michigan Blue Cross and Blue Shield plans have pioneered in the development of new methods to meet the needs of retired workers by having deductions for premiums made from their pension checks. Their agreement with the Bell Telephone Co. in Michigan whereby retired employees could continue coverage at the same rates and with the same benefits has been so successful that it has been adopted almost nationally by all the Bell Telephone subsidiaries and the Blue Cross-Blue Shield plans which serve telephone workers. In Michigan the same plan for deductions from pension checks has been worked out with 15 or 20 other companies and governmental agencies of the city of Detroit and the State of Michigan.[2]

The continuation of coverage of older workers will become increasingly important if more of them continue in the work force as is being urged. In a recent address at the sixth annual conference on Aging at the University of Michigan for example, Mrs. Oveta Culp Hobby, Secretary of Health, Education, and Welfare, stressed the social and economic value of continuing the employment of the older workers.[3] She indicated the desire of the retired worker to continue in employment when she cited recent studies made among beneficiaries of Old-Age and Survivors Insurance which indicate that less than 5 percent of the workers in good health who had retired had done so because they wanted to do so.

Secretary Hobby quoted the experience of several firms that show older workers excel in such matters as accuracy, dependability, steadiness, stability, loyalty, judgment, craftsmanship, and regard for tools and equipment. She also quoted the following finding of the Welford study on age and skills being made at Cambridge University, England, which coincide with experience in this country:

> First, the Welford study has found that decline in physical energy is not nearly as important as had been thought because it has been scientifically proved that older workers with experience are able to develop valuable compensations. It is significant to point out in this regard that increased use of power machines lightens tasks and brings more jobs within the range of older workers, in agriculture as well as industry.
>
> Second, older workers, according to the study, can learn new jobs with comparative ease when the new jobs involve elements

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[1] Baehr, George, and Deardorff, Neva R.: What the Health Insurance Plan of Greater New York Offers Older Persons. *Public Welfare,* 9:61–65 (March) 1951.

[2] Serbein, Oscar: *Payments for Medical Care in the United States,* New York, N. Y. Columbia University Press (in press).

[3] Hobby, Oveta Culp: The Health and Welfare of our Senior Citizens, in *Proceedings of Sixth Annual Conference on Aging of the University of Michigan.* Ann Arbor, The University of Michigan Press, 1953.

similar to the old ones. This proves that employers can shift older workers to different but related tasks and have competent, reliable employees.

In referring to the growing economic problem arising partly out of rigid retirement regulations the Secretary stated:

> More and more people are being shoved off the payroll, only to land in greater or less degree on the taxpayer of preretirement age.
>
> Shall we increase payments or taxation on younger workers to meet the need, or shall we decrease pension payments to the old?
>
> Both these solutions seem unjust. The best answer surely is to increase opportunity and encouragement for older workers to remain self supporting and productive members of society. . . .
>
> If a young man has a heart attack or loses the use of an arm in an automobile accident, society expects him to make a come back—to find some sort of independence even if it is in a different career from the one in which he had started.
>
> If an older man has a heart attack or by arthritis loses the use of his hand, society crosses him off as having outlived his usefulness. We ignore the fact that his brain still holds priceless memories and skills left by experience, that his wisdom is as great as ever, and that he probably needs his work now as much as he did at 45.
>
> The irrational accent on youth in this country and the lack of appreciation for the gifts of wisdom and age which characterize our modern society are at the root of our problem. We are less wise in this area than we were when our Nation was truly a young nation. Proof comes in the fact that 80.6 percent of the males 65 and over were working in 1870. Today only 41 percent of the men 65 and over are in our labor force.

Greater consideration is also being given to the influence that health plans could have on the total amounts paid for permanent and total disability benefits. Pointing to the high cost of such disability benefits, Martin Segal[1] says that a great deal of this cost could be eliminated if there were in effect a medical service program which provided the kind of care, at the early ages, which could either eliminate or arrest conditions which might later develop into total and permanent disability claims. In his opinion, this is a long-range thinking. He says, "When we discuss pension plans, we are not talking about cost today or this year. We must project these costs, actuarially, far into the future. Those who finance or participate in

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[1] Segal, Martin E.: The Administration of Disability and Pension Programs. In *Proceedings of a Conference on Current Problems in Administrative Medicine,* sponsored by the Institute of Administrative Medicine, School of Public Health, Columbia University, New York, 1952, pp. 33–37.

the establishment of pension plans, whether they like it or not, are planning for contingencies that lie 25 and even 45 years in the future."

Mr. Segal noted that, even where it is too late to prevent or diminish total and permanent disability, a medical program has a very useful function, for example, in enabling the disabled employee to live longer. He cited the experience of the pension and welfare fund negotiated by 205 milk companies and 5 locals of the International Brotherhood of Teamsters, AFL, in the New York area. The board of trustees of the fund, in discussing the type physical examination necessary to determine total and permanent disability, decided to give the employee a complete medical examination and to make the results available to the employee's own physician for his guidance in treating the patient. As a result of the medical examination, the trustees not only verify the disability status of the employee, but also assure constructive action in regard to the employee's health needs. The findings brought to light by the periodic examination of these disabled workers, have enabled some workers to take lighter jobs in the milk or other industries.

Maternity Benefits

Maternity protection of employed women has taken on greater significance with the increasing proportion of women in the labor force. Such protection has been achieved in the United States chiefly through voluntary health insurance programs rather than through legislation. The recent development of such coverage is indicated by the fact that less than one-fourth of the 43 firms included in a 1952 study, made by the Women's Bureau, United States Department of Labor, have had maternity benefit provisions for more than 10 years, and more than one-fourth have had them for less than 5 years.[1]

Maternity benefits included weekly cash payments to compensate for some of the loss of income during pregnancy, hospitalization, and surgical (obstetrical) benefits. Weekly cash benefits for pregnancy in most plans were for 6 weeks, and the amounts paid were usually related to earnings, weekly payments ranging from $22 to $26. Hospitalization was the most commonly provided benefit, and most of the plans also contributed toward obstetrical costs.

Each of the 43 plans covered in the Women's Bureau study had hospitalization, and all but 3 had obstetrical benefits. The types of benefits provided by the plans covered in this study were:

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[1] U. S. Department of Labor, Women's Bureau, *Maternity Protection of Employed Women, Women's Bureau Bulletin No. 240,* Washington, U. S. Government Printing Office, 1952, pp. 3, 12, 14.

Benefits provided:	Number of firms
Weekly cash, hospital, obstetrical, and medical	2
Weekly cash, hospital, and obstetrical	26
Weekly cash and hospital	2
Hospital, obstetrical, and medical	1
Hospital and obstetrical	11
Hospital only	1

A study of union- and union-management administered health-insurance plans by the New York Department of Labor in 1951[1] indicated that maternity benefits were available to women members or wives of members in 217 out of 306 plans. Most of the plans giving benefits to wives extended them also to women members. Where this was not done, it was because there were only a few women employees or none at all.

The maternity benefits included in the New York State plans varied as to types of services and amounts allowed. Cash disability benefits, usually for a 6-week period, were provided by 94 plans. Hospitalization was the most common benefit, provided for by 132 plans. About half of the hospitalization plans were Blue Cross, and most of the others provided cash reimbursement on a fixed maximum allowance for periods of 10 to 14 days. Surgical benefits were included in 116 plans, with the benefits tending to follow a pattern of $25 for miscarriage, $50 for normal delivery, and $100 for a Caesarean operation. A flat cash allowance of from $25 to $75 toward maternity expenses was made by 16 organizations. General medical care during or after pregnancy was not usually reported under maternity benefits.

The United Steelworkers of America and the United Automobile Workers, both of the CIO, have health insurance plans with nation-wide coverage providing maternity benefits. The inclusion of such benefits is of special significance because of the influx of women into the metal working industries during war and defense periods.

In 1951, the Bureau of Labor Statistics made a study in the automobile industry of 63 collective-bargaining agreements which contained health and welfare plans. It showed that only 4 plans, with a combined coverage of about 1,000 workers, had no maternity coverage. Four had a separate maternity benefit, with the rest providing such a benefit in connection with accident and sickness disability, hospitalization, and/or surgical benefits. Service-type hospitalization plans, in a majority of instances, granted employees the same privileges in maternity as in other cases. Cash plans either allowed the same daily benefits (generally limited to 14 days) and extra allowances, or provided reimbursement up to a stated maximum (usually 10 times the nonmaternity daily allowance) to be applied against all

[1] New York Department of Labor, Division of Research and Statistics, *Union and Union-Management Administered Health Insurance Plans in New York State,* New York, the Department, 1951, and U. S. Department of Labor, *op. cit.,* footnote p. 27.

hospital charges. Surgical benefits were granted in all plans covering maternity for hospitalization. The amounts payable varied from $40 to $125, with $40, $50, and $75 being the most common.[1]

In the basic steel industry, maternity benefits were included in all but 2 of the 46 health and welfare plans studied in 1951 by the Bureau of Labor Statistics. A summary of the maternity benefits, based on 52 agreements in the steel industry containing 46 health and welfare plans is given in the accompanying table.

Benefits provided	Workers covered		Benefits provided	Workers covered	
	Number (in thousands)	Percent		Number (in thousands)	Percent
Total	434.1	100.0	Hospitalization and surgical	16.6	3.8
Weekly accident and sickness, hospitalization, and surgical	211.1	48.6	Weekly accident and sickness and surgical	.9	(1)
Weekly accident and sickness and hospitalization	201.3	46.4	Weekly accident and sickness	.8	(1)
			None	3.3	(1)

[1] Less than 1 percent.

All benefits in this industry were made available in connection with weekly accident and sickness disability, hospitalization, or surgical benefits. Accident and sickness disability plans providing maternity leave for 6 weeks covered 95 percent of the workers. A similar proportion were under hospitalization plans which included maternity coverage. Under the 70-day uniform Blue Cross contract (covering three-fifths of the workers), the only limitation on maternity cases was to restrict the stay in the hospital to 10 days. Some cash plans (covering over a fifth of the workers) limited hospitalization to 14 days, while the remaining cash plans (with less than a sixth of the workers) granted an allowance for all hospital charges, generally from $75 to $100. Only three programs with surgical benefits failed to extend such benefits to cover maternity cases. The amounts payable for normal delivery in surgical schedules varied from $50 to $75; plans covering 3 of every 4 workers specified $50.[2]

Maternity benefits negotiated by collective bargaining in some of the leading women-employing industries were summarized by the Women's Bureau in 1952 as follows:[3]

1. *The American Federation of Hosiery Workers* (independent) had an industry-wide health-insurance plan for workers in the full-fashioned hosiery branch which provided weekly cash maternity

[1] Rowe, Evan Keith: Health and Welfare Plans in the Automobile Industry, *Monthly Labor Review*, 73: 277–282 (September) 1951.

[2] Eber, Manuel and Paine, Thomas H.: Health and Welfare Plans in the Basic Steel Industry, *Monthly Labor Review*, 73: 447–451 (October) 1951.

[3] U. S. Department of Labor, Women's Bureau, *Maternity Protection of Employed Women, Women's Bureau Bulletin No. 240*, Washington, U. S. Government Printing Office, 1952, p. 12.

benefits based on 60 percent of average earnings for 6 weeks, a maximum of $7 a day reimbursement for hospitalization for a maximum of 12 days, and an allowance of $15 for delivery room charges.

2. *The Amalgamated Clothing Workers of America* (CIO) had a nationwide welfare plan for most branches of the industry, providing only obstetrical benefits of from $25 to $100 in maternity cases.

3. *The International Ladies' Garment Workers' Union* (AFL) with most of the membership covered by health and welfare benefits paid less than 1 percent of local benefit funds for maternity cases. They usually consisted of a $50 cash allowance, but most locals did not include such protection. Health centers established by the union did not usually have prenatal clinics or any special services for pregnant members.

4. *The Textile Workers Union of America* (CIO) has no fixed plan of benefits, although almost 90 percent of the membership is covered by insurance plans financed by the employer. Union representatives estimated that more than three-fourths of women members had maternity benefits, which usually included weekly cash benefits for 6 weeks, hospital benefits with maximum daily allowances from $3.50 to $9 for a maximum of 2 weeks, and maximum obstetrical allowances of $50 for normal delivery, $25 for miscarriages, and $100 and $150 for Caesarean and ectopic deliveries.

5. *The New York Hotel Trades Council* (AFL) had negotiated an insurance plan providing weekly cash maternity benefits for 6 weeks, Blue Cross hospitalization, prenatal and postnatal care at the health center, and free obstetrical care for delivery.

Section III

Program Characteristics

Methods of Providing Benefits

Insurance company, Blue Cross, and Blue Shield programs provide most of the protection that exist today against medical and hospital bills. Membership in the older type programs developed by employers or employees or both of a given firm has remained the same or diminished. The continuation without change of some of the older plans has been guaranteed by clauses in collective bargaining agreements. In other instances older programs have been replaced by the newer type.

Because of the rapid development of health and welfare funds and the desire to provide benefits without too long a delay after funds have been set up, most unions have purchased their coverage from insurance companies and from Blue Cross hospital and Blue Shield medical care plans. These programs are designed principally for coverage of hospitalized illness, therefore affording little opportunity for health education, early detection of disease, and treatment in the early stages of an illness. Unions have recognized these limitations and have worked with varying degrees of success with the voluntary programs in an effort to secure greater benefits through them.

In some instances, coverage has been obtained from cooperative prepayment organizations and from group practice clinics. As a rule, these programs provide some preventive and diagnostic services and often physicians' services in the office and the home as well as in the hospital. The Health Insurance Plan of Greater New York, the Permanente Health Plan, and the Group Health Cooperative of Puget Sound are examples of cooperative and group-practice programs serving union groups. Details on the services provided by the Health Insurance Plan of Greater New York to one union group are given in section V.

A limited but growing number of union groups handle their own benefits. In some instances, reimbursement is made in cash, either from a fund or from an insurance company set up by the union; in others, the unions have established health centers to provide preventive, diagnostic, and various other services to their members. Services at the center are usually supplemented by some form of voluntary health insurance covering hospitalization and physicians' care during hospitalized illness. Section V of this publication describes some of these programs in detail.

Characteristics of Major Voluntary Health Insurance Plans

Insurance company, Blue Cross, and Blue Shield programs provide protection chiefly against illness cared for in the hospital. The

principal physicians' services provided are for surgery and obstetrical care. Physicians are in private practice, and the patient has free choice of hospitals and physicians associated with the plan. In most instances, this means that the patient has free choice of all hospitals and physicians within the area served by the plan.

Benefits provided by these programs fall into one of three classifications:

1. *Cash indemnity:* Payments are made in cash, according to a fee schedule, either to the insured or to the hospital or physician as a credit toward the patient's bill.

2. *Service:* Specified types and amount of service are guaranteed to the insured regardless of cost. Hospitals and physicians receive payment for these services from the plan.

3. *Combined service and cash indemnity:*

Medical care: Payments are made on the basis of a fee schedule; where insured's annual income is below a specified amount, payment is accepted by physician as full payment for services rendered, but where patient's income exceeds specified figure, the sum is applied as credit on his bill and attending physician may make additional charges.

Hospitalization: Plan pays a specified daily rate toward hospital charges for room and board, and guarantees specified types and amounts of supplemental benefits regardless of cost.

The selection of a particular type of program depends on many factors, including age, sex, marital status, and socioeconomic characteristics of the employees to be covered, the amount and types of benefits to be provided, and the method of financing the program. These same factors influence the cost of the program as well. A detailed consideration of these points is included in appendixes 29 and 30.

Insurance Company Hospital and Medical Care Contracts

With only one or two exceptions, insurance company contracts provide indemnity benefits. The provision of such benefits and the large areas covered by the companies have made it possible for them to assure uniform coverage to large and scattered union groups. Policies are adapted to meet the needs of special groups, and "package contracts" offer unions and other employed groups a chance to purchase hospitalization and medical coverage along with life insurance, sickness and accident, and various other health and welfare benefits. There is great variation in contract provisions, but the salient features of hospital and medical coverage under insurance contracts were recently summarized as follows:[1]

[1] Editorial Staff of Prentice Hall, Inc.: *Successful Employee Benefit Plans.* New York, Prentice Hall, Inc., 1952, pp. 49–53, 60–63.

When the insurance company underwrites a *hospitalization plan*, it issues a group policy to the employer, setting forth in detail the terms of the contract. Each employee who is covered by the group policy receives a certificate summarizing the provisions of the group policy that principally affect him. . . .

Daily benefits.—The policies provide for reimbursement to the insured of a flat daily benefit for a stipulated number of days for continuous hospital confinement or for each admission for a different illness. Any daily benefit desired by the employer is available; the daily benefits may run for any number of days. Usually the payments range from $4 to $7 per day for 31 days for any one hospitalization period. There is usually no limit to the number of days that benefits are payable during the year if each hospitalization is for a different illness. A few policies provide for reimbursement up to a certain amount, the rate per day and the duration not being specified. The trend is to increase the benefits to meet union demands.

Special hospital services.—Cash indemnity plans make a specific reimbursement for additional hospital charges. The amount is usually based upon the daily benefit, ranging from 5 to 31 times the daily indemnity. There is no restriction as to the type of service except that coverage is not granted for doctors' fees or nurses' room or board.

Choice of hospitals.—The insured may be hospitalized in any legally recognized hospital located anywhere in the United States or Canada.

Waiting period.—There is usually no waiting period, except for maternity cases and removal of adenoids or tonsils. Some policies waive the maternity waiting period.

Maternity benefits.—Maternity benefits are usually not payable if pregnancy exists on the effective date of the policy, or if it occurs within 9 to 12 months after the employee joins the insured group. On the other hand, some policies place no restrictions on employees who become members on the date the plan goes into effect. The daily benefit payment is usually limited to 10, 12, or 14 days for hospital confinement caused by any one pregnancy or resulting childbirth or complications.

Tonsils and adenoids.—Insured plans usually provide for a waiting period before hospitalization for removal of tonsils or adenoids. The number of days for which benefits will be paid is also limited.

Outpatient service.—Insured plans do not usually include outpatient service unless the employee receives emergency care within 24 hours after an accident, or undergoes an operation in the hospital. Even then, only part of the cost is covered.

Exclusions.—Insured plans exclude hospitalization for industrial injuries or diseases for which the employee is entitled to benefits under workmen's compensation laws, hospitalization for military service-connected disabilities, and for plastic operations for cosmetic or beautifying purposes.

Female employees.—Female employees receive the same benefits as male employees. If the employer pays part of the pre-

mium, the cost to the female employees is usually the same. . . .

Dependents.—Under almost all cash indemnity hospital expense insurance plans that cover dependents, the daily benefit allowance for dependents is less than that for the insured employee. As the maximum allowance for special hospital services is usually based on the daily benefit, this allowance is also lower for the dependents than for the insured employee. Of course, a plan providing equal benefits for dependents can be written. A dependent need not be financially dependent upon the subscriber. . . .

Uniformity of benefits and premiums.—Under insurance company plans an employer may procure any benefits he chooses for his employees. Although rates may vary among insurers, each carrier offers the same benefits for the same premium throughout the country. As the benefits are a cash indemnity, it is customary to vary them with the locality. For example, employers in two different cities might want a policy that provides 75 percent of the daily cost of a semiprivate room. In one city the policy would provide a daily allowance of $8; in another, $4. A national employer may have one group policy that provides proportionate benefits, but different cash indemnities, for his employees in various communities. Benefits and premiums to the employees covered by a group hospital insurance policy may be on a sliding scale in relation to salary.

Transfer and termination.—All hospital expense insurance underwritten by a regular insurance company automatically ceases on the date of the termination of the employee's employment. For the purposes of the insurance, termination of employment means cessation of active work, except under the following circumstances:

1. If the employee is absent from work on account of sickness or injury, he is considered employed until the employer terminates his employment.
2. If the employee is absent from work because of a temporary layoff, he is considered employed until the employer terminates the employment. The group policy, however, limits the layoff period during which an employee may be considered employed. . . .

Claims.—Written notice of hospital confinement must be given to the insurance carrier within a definite number of days, usually 20, after the commencement of the hospital confinement. . . . Insurance carriers usually furnish the insured with forms on which a hospitalized employee may authorize the carrier to make payment direct to the hospital. In several large metropolitan areas, insurance companies have made arrangements with cooperating hospitals to pay them direct. The insurance companies furnish the hospitals with the names of the group enrollments and a telephone call by the hospital to the insurance company verifies the contract.

When an insurance company underwrites a *medical care plan*, it issues a group policy to the employer, setting forth in detail the terms of the contracts. Certificates issued to the covered employees summarize the provisions of the group policy that principally affect the

employee. . . Since the policies vary widely in scope of benefits, analysis of a specific plan would not be helpful. The features that require special consideration are summarized as follows:

Income limit.—Employees earning any income may be covered by an indemnity plan underwritten by an insurance company. Some employers, however, choose to vary the benefits according to the salary of the employee.

Benefits.—The indemnity policy most commonly written reimburses the insured for surgical expense only. The insured employee is reimbursed for the surgical fee up to the amount listed in the "Schedule of operations" for the operation performed, but in no event is the allowance more than the actual fee charged by the doctor. Typical schedules are the "$150 maximum" plan and the "$250 maximum" plan. Each specific operation in the higher maximum plan is increased proportionately. The policies also specify a maximum amount that will be paid during any one continuous period of disability, should more than one operation be required. This amount ranges from $150 to $300. Furthermore, if two or more operations are performed in the same operative field, the reimbursement will not exceed the amount specified in the schedule for the operation for which the largest amount is payable. The phrase "continuous period of disability" includes successive periods of the same or a related disability.

As previously mentioned, almost all medical care plans provide reimbursement for surgical expense only. Among those that offer reimbursement for medical nonsurgical expense, the majority are limited to reimbursement of costs of physician's visits while the employee is in the hospital, or to "inhospital" benefits. Some provide for reimbursement of the cost of a physician's visit at the home of the insured, at the physician's office, or in the hospital. Under a cash reimbursement program providing nonsurgical care, payments to employees are usually up to $3 for a hospital or home visit and $2 for an office visit, not exceeding 50 visits per year. The number of visits per week is also limited. Coverage generally excludes the first two or three visits in illnesses, but includes the first treatment in accident cases. Some policies also provide limited reimbursement for additional costs such as X-rays, electrocardiograms, laboratory analysis, and so on.

Exclusions.—Medical expense insurance written by insurance companies generally excludes occupational injuries or illnesses that entitle the insured to benefits under workmen's compensation or occupational disease laws. It also excludes plastic surgical operations for cosmetic or beautifying purposes, if the condition existed at the time the policy was written. The coverage in the policies written by the large insurance companies is otherwise usually all-inclusive, even covering chronic conditions, alcoholism, a heart condition, and nervous breakdowns. Some small companies offer very limited policies for low premiums, in an effort to get business. In some cases, the exclusions under these contracts permit the carrier to evade almost any claim. An employer should study the exclusions in a

policy very carefully so that he will not be tempted by a cut-rate premium to buy a policy that is not satisfactory.

Choice of physician.—The employee may choose any legally qualified physician or surgeon.

Waiting period.—Nearly all cash indemnity plans require a waiting period for maternity cases, tonsils and adenoids, and known preexisting conditions.

Maternity benefits.—The indemnity policy reimburses the insured, up to the amount listed in the schedule of operations, for surgical fees for delivery, Caesarean section, abdominal operation for extrauterine pregnancy, and miscarriage.

Tonsils and adenoids.—The insured is reimbursed for surgical fees paid for the removal of tonsils or adenoids, up to the amount listed in the schedule of surgical operations.

Female employees.—Female employees usually receive the same benefits as male employees. If the employees are predominantly female, the cost of the insurance is higher.

Dependents.—Group medical expense insurance policies usually have the same requirements and provisions for dependents as group hospital expense policies have.

Uniformity of benefits and premiums. Insurance companies will underwrite surgical care or surgical and nonsurgical medical care plans with any reasonable benefits desired by the employer. The same benefits and the same premiums are available throughout the country, but may vary with different companies.

Insurance companies will also write a group policy containing a sliding scale of benefits and premiums. For example, one plan now in effect classifies the employees into four classes according to the work performed by each. . .

Claims.—Claims for physicians' fees are filed in the same manner as for hospital expense. To date, the insurance companies have not established a system whereby they pay the physician direct.

Insurance Company Major or Excess Medical Expense Contracts

Insurance companies have recently begun to issue group medical expense contracts usually referred to as "catastrophic" coverage to cover unusually expensive or long-term illnesses. The contract is similar to other group insurance contracts in that a master policy is issued to the employer and certificates are issued to the insured employees. No physical examination is required. The insurance is designed to meet the costs that normally exceed the protection of the usual group insurance plan. It is anticipated that the usual group hospital and medical care plans will pay the deductible amount, or that the employee can pay that amount without undue financial strain.

The distinctive features of excess medical care insurance are:[1]

[1] Editorial staff of Prentice Hall, Inc.: op. cit., pp. 63–66.

1. *Deductible amount.*—The policy has a deductible amount of $300 to $500, which is paid by the insured individual.

2. *Coinsurance clause.*—The carrier pays, for each separate illness or injury by any one cause, 75 percent of the expenses in excess of the deductible amount, to the maximum stated in the policy. The coinsurance clause serves as a check on incurring needless expenses.

3. *Maximum amount.*—The maximum amount of the policy is large, $2,000 to $5,000.

Income limit.—Excess medical expense plans impose a minimum income limit for eligibility, instead of a maximum limit. Tests made by employers and the insurance carrier show that the employee who earns less than $5,000 per year is not sufficiently interested to enroll in the plan. One company that adopted the plan established a classification of department heads, managers, salesmen, and executives. Of the 150 eligible with earnings under $5,000, only 1 enrolled, whereas 80 percent of those earning over $5,000 enrolled.

Benefits.—As stated above, the insurance carrier pays 75 percent of the medical expense for any one illness, in excess of the deductible amount, up to the maximum stated in the policy. Each new illness or injury is entitled to its own maximum. Medical expense is defined as any expense incurred by the insured for the diagnosis, treatment, or care of a nonoccupational, accidental bodily injury or disease. This includes physicians', surgeons', and nurses' fees, hospital and clinic charges, X-ray examinations and treatments, laboratory tests, anesthesia, drugs and medicines, and all other therapeutic services and supplies.

Exclusions.—The policy has these two provisions:

1. The charges must be reasonable.
2. The service must be necessary.

From a practical standpoint, a charge is considered reasonable if it is one that would be charged under similar circumstances by good hospitals, physicians, or nurses residing in the same area. The policy coverage is very broad: only accidents and illnesses covered by workmen's compensation insurance are excluded. Preexisting conditions are covered, provided the employee is at work when the policy is written. Even psychiatric treatment is covered, and also dentistry, if directed by the insured's physician.

Choice of physician.—The insured may choose any physician licensed to practice medicine.

Waiting period.—There is no waiting period. All conditions are covered from the day the policy is written, provided the employee is at work that day.

Dependents.—A plan may or may not cover dependents. The employee's spouse and all unmarried children under 21 years of age are considered dependents. If dependents are included, the premium is double that for the employee alone.

Uniformity of benefits and premiums.—Excess medical care plans are flexible. The following four policy plans are offered as examples:

Deductible	Maximum	Monthly premium
Plan 1: $300	$2,000	For employee, $2.10. Employee and dependents, $4.20.
Plan 2: $300	5,000	For employee, $2.25. Employee and dependents, $4.50.
Plan 3: $500	2,000	For employee, $1.75. Employee and dependents, $3.50.
Plan 4: $500	5,000	For employee, $1.90. Employee and dependents, $3.80.

Claims.—Excess medical care plans are indemnity plans, but the carriers will pay the hospital and doctors' bills direct if requested by the insured. In cases of prolonged illness, the bills are paid from time to time, as received.

Termination and retirement.—Like the usual group hospitalization and medical care insurance, the insurance terminates when employment is terminated. Unlike the usual group policy, a retiring employee may remain in the insured group and continue to pay the regular premium through the employer. The employee also has the privilege of converting to an individual policy within 31 days.

A clue to the interest in these excess medical expense contracts is found in their recent adoption by three major companies—Sears, Roebuck & Company and the Socony-Vacuum Oil Co. for all employees, and the General Motors Corp. for salaried employees earning $5,000 a year or more.[1]

Under the Sears, Roebuck plan, the benefits payable under the basic hospitalization-surgical plan are deducted from the total cost of the illness; an additional 5 percent deduction is made of the employee's annual earnings, subject to a minimum of $200 and a maximum of $500, according to yearly income. The employee collects 75 percent of the balance of the cost of the illness, up to a maximum of $5,000. Dependents are not covered. The cost to the employee is 35 cents per each 4-week period, in addition to the basic hospital-surgical charge of $1 for an employee alone, $2 for an employee with 1 dependent, and $3 for an employee with 2 or more dependents.

The Socony-Vacuum Oil Co.'s extended medical insurance plan provides for the payment of 75 percent of the employee's medical expenses during a single medical expense period, up to $5,000, after first deducting benefits paid under the basic hospital-surgical plan plus $100. If the employee's basic annual earnings exceed $10,000, the $100 deductible amount is increased to $150. Dependents are covered, as well as retired employees who had been covered under the basic plan for at least 5 years immediately preceding retirement. The cost for single employees is $1.44 a month in addition to the $1.04 monthly cost for basic hospital-surgical insurance; for those with dependents, it is $3.44 a month plus $4.20 for the basic plan.

[1] Major Medical Expense Plans are Adopted by Three Large Firms, *Employee Benefit Plan Review*, 7 : 11–12 (Fall) 1952.

The General Motors plan for salaried employees earning $5,000 or more a year also covers dependents. After deduction of the amounts paid or the services provided under its basic Blue Cross-Blue Shield hospital and surgical expense program, $100 additional is deducted from the total expenses for employees with salaries up to $12,000 a year. For those earning more, there is a graded additional deductible amount up to $300. After the deductions are made, the supplementary plan pays 80 percent of the expenses up to $10,000 incurred during a single medical expense period by an employee; the top limit for dependents is $5,000. The cost to a single employee is $1.25 a month in addition to the basic charge of $1.50 for hospital-surgical coverage; employees with 1 dependent pay $2.61 in addition to the basic $3.89; and those with 2 or more dependents pay $4.11 in addition to the basic $3.89.

Blue Cross Hospital Plans

Blue Cross plans were originally organized as service programs, but about one-third of these plans now provide cash indemnity or combine service with cash indemnity benefits. Most Blue Shield plans combine service with cash indemnity. In 1951, the percentage distribution of Blue Cross and Blue Shield enrollment according to type of benefit was about as follows:

Type of benefit	Percent of members eligible	
	Blue Cross	Blue Shield
Total	100.0	100.0
Cash indemnity	19.0	31.2
Service	67.8	2.9
Combined service and cash indemnity	13.2	65.9

Most of these plans offer three types of contracts—individual, two-person, and family. Benefits are generally the same under each type of contract, except for provision of maternity benefits under family contracts. Premiums vary according to the type of contract and also according to whether enrollment is on a group or nongroup basis. A plan may offer several contracts providing various types and amounts of benefits.

Although the plans must meet certain standards in order to use Blue Cross or Blue Shield insignia (appendixes 31 and 32), each plan determines its own benefits and premium rates and administers its own program. Blue Cross enrollment is available to national groups through Health Services, Inc. Outstanding features of Blue Cross contracts are summarized as follows:[1]

[1] Editorial staff of Prentice Hall, Inc.: Op. cit., pp. 54–59.

As the plans vary widely with the locality, there is no "typical" Blue Cross plan, but the salient features to which consideration should be given when selecting a plan may be summarized as follows:

Daily benefits.—Blue Cross plans usually provide for room and board, including special diets and general nursing, in a semiprivate room or ward in a member hospital. Benefits are payable for a stipulated number of days, ranging from 21 to 30, for each admission for a different ailment, with partial benefits for an additional period. The partial benefit period runs as high as 180 days under some plans. Partial benefits are in the nature of a stipulated dollar or percentage discount from the hospital's charges per day. In some plans a uniform amount is payable throughout the benefit period. Some plans limit the number of days for the year, but the current trend is to allow a maximum number of days for each illness, instead of for the year.

Blue Cross makes a daily allowance toward the room charges to subscribers who take a private room in the hospital. During the partial benefit period the daily allowance is cut about 50 percent. Some plans allow a maximum total amount or the daily allowance, whichever is greater. Thus, if a member is in a private room only two or three days, his entire bill might be paid.

Special hospital services.—All Blue Cross plans provide for room and board, general nursing care, use of the operating room, laboratory service, and routine medications and dressing. In addition to these basic services, plans provide for specified extra hospital charges, which vary with the plan. There is no limit on the cost of the services provided, but only those specified in the contract are allowed. Under some plans special hospital services are not allowed to members who are in private rooms.

Services usually allowed are the following:

Oxygen and use of equipment for administering oxygen.

Anesthesia supplies and use of anesthesia equipment; administration of anesthesia only if administered by an employee of the hospital.

Dressing and plaster casts.

Use of cardiographic equipment.

Basal metabolic examinations.

Use of physiotherapeutic equipment.

Laboratory and X-ray examinations consistent with the diagnosis and treatment of the condition for which hospitalization is required.

Use of cystoscopic room and equipment.

Choice of hospital.—Blue Cross plans require hospitalization in a local member hospital, that is, one with which the hospital association has a working contract. Almost all legally recognized hospitals are member hospitals. If these are all occupied, the subscriber is put on a waiting list, or occupies a private room and pays the additional cost.

Through reciprocity of services, Blue Cross plans provide hospitalization in member hospitals located out of the area covered by the hospitalized subscriber's plan.

Waiting period.—Maternity care, tonsil and adenoid cases, and preexisting conditions usually require a waiting period ranging from 6 months to a year. In all other cases, benefits are available immediately after employment. Some plans waive waiting periods in groups of 25 or more when the employer contributes toward the subscription costs, if 75 percent of the employees are enrolled and 75 percent of the married employees have family contracts.

Maternity benefits.—The plans usually reduce the number of days for which daily benefits are available, but allow special hospital services, including use of the delivery room. Some plans limit the total amount allowed. . . .

Tonsils and adenoids.—The daily benefits, in many instances, are limited to 1 day for members under 12 years of age and 2 days for members 12 years of age and over. Necessary special hospital services are also allowed. Usually, the benefits are not available until the member has been enrolled continuously for 6 months.

Outpatient service.—Benefits are not provided for outpatient service, except (1) for emergency service within 24 hours after accidental injury and (2) for use of the operating-room facilities. Usually, the full cost is not paid, but an allowance is made toward the hospital bill.

Exclusions.—Broadly speaking, Blue Cross covers any illness that is treated in a general hospital. Benefits are not provided for mental or nervous disorders; workmen's compensation cases; communicable diseases requiring isolation or quarantine; hospitalization furnished under Federal, State, or other laws; rest cures; and admissions primarily for diagnosis or physical therapy.

Female employees.—Female employees usually receive the same benefits as the male employees, at the same subscription rate.

Dependents.—A family contract entitles dependents to the same benefits as the subscriber, except maternity benefits, which are available only to the wife enrolled under a family contract. The wife may be the employee who subscribes to the plan. A dependent need not be financially dependent upon the subscriber. . . .

Uniformity of benefits and premiums.—Benefits and premiums to employees in a group cannot be on a sliding scale. Thus, the highest paid executive and the lowest paid clerk pay the same premium for Blue Cross hospitalization and receive the same benefits. . . .

Transfer and termination.—When a subscriber changes his job, he may continue his membership by making payment direct to the plan at a slight increase in rate, or he may apply for transfer to an existing Blue Cross group at his new place of employment. There need be no lapse of coverage. If the subscriber moves to another community he may enroll in the Blue Cross plan there without a waiting period. He may continue his membership after retirement and after he reaches the age of 65, although he cannot enroll after the age of 65, except in large Blue Cross groups where the age limit is waived. . . .

Claims.—A member need only show his Blue Cross identification card to be admitted to the hospital. No questions are asked; no financial references, no advance payments, no employer verification of illness, no other claim forms are necessary. The member pays only the portion of his bill that is not covered by his contract; Blue Cross pays the balance direct to the hospital. . . .

Blue Shield Plans

Blue Shield, like Blue Cross, usually has three classes of contracts: (1) individual, which covers only one person; (2) husband and wife, which covers the employee and his or her spouse; and (3) family, which covers the employee, his or her spouse, and all unmarried children under 18. The benefits under each are the same, except that the family contract offers maternity benefits. Features of these contracts are summarized as follows:[1]

Income limits.—There is usually no income limit for enrollment purposes, but the benefits are applied as credit to the total charges for professional services if the income exceeds a specified limit. These income limits range from a low of $1,500 for a single subscriber and $2,500 for a family, to $2,500 for a single subscriber and $6,000 for a family. The most usual limits are $2,500 and $4,000, respectively.

Benefits.—Blue Shield plans provide general surgical care only, or surgical and medical (nonsurgical) care. A few plans also offer home and office services. The surgical care allows a specified amount for general surgical services, which usually include treatment of fractures or dislocations and maternity care. The amount allowed for a specific operation is limited to the amount listed in the schedule of operations included in the contract. Employees earning above a certain amount must pay the difference between the allowance and the physician's bill. The contract also specifies a maximum amount that will be paid for any one disability. Some plans require that the patient be hospitalized to receive allowance for surgical and obstetrical care.

Some plans require that the patient be hospitalized to receive benefits for nonsurgical medical care; others pay for home or office, as well as hospital visits of physicians. The plans limit the allowance per daily visit and the number of visits. Patients whose income exceeds a certain amount are responsible for higher fees charged by the physician. Participating physicians agree not to charge patients whose income is below a certain amount a fee higher than that specified in the contract.

In some Blue Shield plans, allowance is not made for the first two or three visits. Plans that offer "other services" usually

[1] Editorial staff of Prentice Hall, Inc.: Op. cit., pp. 66–99.

make an allowance for anesthesia, diagnostic X-ray, allergy tests, and the like, with a maximum allowance for each service.

Exclusions.—Plans exclude industrial injuries or diseases that are covered by workmen's compensation laws and care furnished under Federal, State, or other laws, or by a medical department maintained by the employer. Most plans also exclude dental or nursing services; plastic or cosmetic surgery for a condition existing at the time of enrollment; alcoholic or drug addiction; congenital anomalies; drugs, appliances, and eyeglasses; functional disorders of the mind or nervous system; rest cures; preexisting conditions during the first 11 months of enrollment, unless waived in the group contract because of a large percentage enrollment.

Choice of physician.—The subscriber may choose any "participating" physician. A participating physician is one who has entered into a service agreement with the organization administering the plan. A nonparticipating physician is often paid the same allowances, but he may make an additional charge to the subscriber, regardless of the income status of the subscriber. Almost all of the best physicians in a community participate in the Blue Shield plan.

Waiting period.—Plans usually provide a 10-month waiting period for maternity cases and 6 months for tonsils and adenoids. Some plans provide a waiting period for elective operations, other for preexisting conditions. Plans usually provide waivers of the waiting period under certain conditions.

Maternity benefits.—Maternity cases are given the same benefits as any other illness. The schedule of operations includes obstetric delivery, Caesarean section, abdominal operation for ectopic pregnancy, and miscarriage.

Tonsils and adenoids.—The schedule of operations includes removal of tonsils and adenoids.

Female employees.—Female employees receive the same benefits as male employees, for the same premium.

Dependents.—Blue Shield plans usually have the same provisions and requirements for dependents as the Blue Cross plans, since they are sold together as one "health package."

Uniformity of benefits and premiums.—Blue Shield plans vary with the organization sponsoring the plan. Occasionally an organization offers more than one type of plan. For example, the United Medical Services, Inc., which covers the New York metropolitan area, offers three types:

1. Surgical plan, which pays a specified amount toward the physician's fee for surgical operations.
2. Surgical-medical plan, which offers the same surgical benefits as the surgical plan, and, in addition, provides specified medical care for nonsurgical hospitalized cases.
3. General medical plan, which provides surgical benefits and medical benefits for physician's calls at the home or in the hospital and for visits to a doctor's office.

The monthly subscription rates for an individual, at this time (April 1952), are 56 cents, 72 cents, and $1.60, respectively; for a family, $2.56, $2.96, and $4.00, respectively.

Transfer and termination.—Blue Shield plans have the same provisions for transfer of membership and change of contract as do Blue Cross plans.

Claims.—A subscriber merely shows his identification card to his doctor. Blue Shield pays the doctors the scheduled allowance and the subscriber pays any difference between the doctor's fee and the allowance.

Potentialities of Blue Cross, Blue Shield and Insurance Company Coverage

The advantages and disadvantages to both the company and its employees of Blue Cross and insured hospitalization plans were enumerated by 123 executives interviewed in a recent study made by the University of Michigan. In companies which had both types of coverage the executives were asked to compare the merits and shortcomings of each. The following represents their views:[1]

Advantages of Blue Cross.—The advantages most often mentioned for Blue Cross plans were as follows:

> First, employees severing employment can continue their Blue Cross protection on a direct payment basis. It was thought that such employees, especially young women leaving gainful employment and old employees nearing retirement, appreciate the privilege of continuing their hospitalization coverage even at the higher rates normally charged them on an individual basis. Under an insured hospitalization plan the coverage is usually terminated upon termination of employment. However, in a few limited cases insured hospitalization and surgical plans have been written to cover groups of retired employees.
>
> Second, an employee who leaves one firm for another may apply his former membership against the waiting period in Blue Cross plan of the second firm, even if it is in another community.
>
> Third, it is very simple for the employee to make use of Blue Cross. If his physician recommends hospitalization, he need only present his Blue Cross identification card to a participating hospital in order to be admitted. There is little of the delay and questioning often otherwise necessary in order to determine the applicant's credit. The Blue Cross organization pays the hospital and other incidental expenses of the insurance within the limits specified in his certificate. He pays the remainder of his hospital bill. Under an insured plan, the employee normally pays the hospital charges, then files a claim with the insurance company or employer and is later reimbursed up to the limits outlined in his certificate. However, in a few areas arrangements have been made to have some insur-

[1] Strong, Jay V.: *Employee Benefit Plans in Operation,* Washington, D. C., Bureau of National Affairs, Inc., 1951, pp. 186–190.

ance companies make payment directly to the hospital rather than to covered employees.

Fourth, under Blue Cross, the benefits to which an employee's dependents are entitled are usually the same as those available to him. This is not necessarily an advantage over all insured plans, since some of them also provide the same benefit for dependents as for employees if the appropriate premium is paid.

Fifth, many Blue Cross plans protect new-born babies from birth and also provide coverage for collateral dependents, such as mothers and fathers. In addition, most Blue Cross plans provide that children who reach the age of 19 or marry can take out certain Blue Cross contracts in their own names.

Because Blue Cross plans operate under a nationally known symbol, some subscribers no doubt feel that they are being protected by one national organization. As was mentioned earlier, each Blue Cross organization actually operates on a local basis. However, they are all required to meet certain prescribed standards and in a sense are bound together in that they share common help and advice. Nonetheless, in any Blue Cross plan it is the local management which occupies a place of paramount importance, and the better such management performs its function the better will be the Blue Cross organization in that locality.

Advantages of insured plans.—Some executives interviewed preferred insured hospitalization plans rather than Blue Cross plans. They gave several reasons for this preference, as follows:

First, under an insured plan a company is able to obtain uniform coverage throughout its organization even though its plants are located in different States. Usually this is impossible under Blue Cross plans, even though an effort is being made to unify their terms throughout the country. Representatives of multiplant companies stated that uniform coverage is important, especially if employees are transferred from one location to another. Also, union negotiations on the subject may be easier if the plan is companywide. However, it should be noted that, due to different local conditions, benefits considered adequate in some communities will be inadequate in others. If the benefit schedule is geared to the high-cost communities, overpayment in low-cost localities can be prevented by specifying that reimbursement will be made for only the actual charges up to the stated maximum. Some employers had shifted to insured programs in order to secure companywide, uniform hospitalization coverage for their employees.

Second, some employers prefer insured plans because they think these involve less administrative work. Under an insured program an employer may purchase accident and sickness benefits, group-life insurance, hospital, surgical and medical reimbursement coverage from the same insurance company. Under this arrangement the employer deals with only one organization in the settlement of claims and the payment of premiums. A multiplant employer would have to deal with a number of local Blue Cross organizations separately, and, of course, Blue

Cross does not offer all of the above-named coverages to any employer.

Third, although probably about 4,000 hospitals, with perhaps 85 percent of all general hospital beds, participate in Blue Cross, some employers pointed out that not all of the hospitals in communities where their plants were located were Blue Cross participating hospitals. Thus, if members are restricted to the use of only participating hospitals, the usefulness of Blue Cross is limited. Under an insured hospitalization plan the employee is free to choose any hospital. A few employers mentioned that some hospitals were dissatisfied with their present agreements with Blue Cross. In some cases, contracts made between Blue Cross organizations and hospitals contained specified fees which were inadequate to cover the increased cost of the designated services.

Fourth, female employees who are on the payroll when an insured hospitalization plan is established and who apply for membership within 31 days after they become eligible have immediate maternity coverage. In Blue Cross plans a 9-month waiting period is usually required for all maternity benefits, although some Blue Cross plans waive this restriction where a large number of subscribers are covered. Also, the maximum duration of maternity benefits under Blue Cross is usually 10 days as compared with 14 days under insured plans. But because of the crowded conditions of many hospitals, maternity cases are seldom kept in the hospital over 10 days under either type of coverage.

It is extremely difficult to make cost comparisons between a Blue Cross and an insured hospitalization plan, largely because the benefits under the two types of coverage are not identical. It is interesting to note that some employers with Blue Cross coverage contended that it was cheaper than insured plans while other employers with insured programs claimed that their costs were lower than the cost of Blue Cross. One point often made by advocates of Blue Cross coverage was that administrative expenses are low. Blue Cross officials claim that, out of every dollar of subscription income, a national average of 86 cents is paid to hospitals for subscribers' benefits. On the other hand, some officials of Blue Cross admit that in some communities insured rates are lower than the Blue Cross rate, but for family coverage it may be higher.

The policy followed by either a Blue Cross organization or an insurance company in building up contingency reserves will reflect itself in current rates charged for hospitalization benefits. Insurance companies have traditionally felt the need for establishing contingency reserves. Under Blue Cross certain service benefits are provided. In an inflationary period, the dollar cost of these services is likely to rise. Evidence of this can be seen in the advances in Blue Cross rates which took place in 1947–1950. To the extent that insurance companies charge dollars for "dollar benefits," their method ought to give more rate stability than would be found under Blue Cross. Of course, if the "dollar benefits" are increased under an insured plan, the rates charged therefor would also need to rise.

It should be remembered that insured plans are written on an experience rating basis so that the cost for a particular group with very favorable experience may be reduced substantially. On the other hand, Blue Cross rates are based on the experience of all subscribers to a given Blue Cross organization. Thus, strictly from a cost point of view, an employer who expects a high claim rate might prefer Blue Cross while an employer who anticipates a very low claim rate might favor an insured plan.

In discussing the potentialities of Blue Cross, Blue Shield, and insurance companies in meeting union health needs, Harry Becker, then director of the UAW–CIO Social Security Department and of the UAW–CIO Health Institute, as well as labor representative on the board of trustees of the Michigan Hospital Service (Blue Cross) and of the Michigan Medical Service (Blue Shield), stated that Blue Shield, as a medical society-sponsored organization, could, more easily than most organizations, develop a comprehensive medical service through contractual arrangements with physicians on an areawide basis. In Mr. Becker's opinion, if Blue Shield is to meet these needs, provision must be made to assure that payments to physicians under the program constitute full payment for services provided; that coverage is extended during periods of layoff and sick leave; that there is an integration of coverage with Blue Cross to eliminate gaps such as chronic illness and care in home and office, including diagnostic services; and that the base of its policymaking boards of trustees be broadened to include a substantial representation of the persons for whom the program is intended.[1]

The difficulties which unions experience in securing adequate medical coverage is exemplified by the recent experience of one automobile union. This group subscribed for surgical benefits through the local Blue Shield plan, which provided full payment for services to individuals whose annual family income was $2,500 or less. Since the great majority of workers in the union earned more than this, Blue Shield payments amounted to about 62 percent of the actual bill for the average operation. Blue Shield later raised the income limit to $5,000 for workers with families and $3,750 for single workers. The unions purchased this program and supplemented it by coverage for nonsurgical hospitalized cases through an insurance company group contract. The two contracts combined provide relatively complete protection for hospitalized illness of average duration.[2]

The need for additional benefits has likewise been stated by insurance companies and medical groups, as well as by management representatives.

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[1] Becker, Harry: Organized Labor and the Problem of Medical Care. *The Annals of the American Academy of Political and Social Sciences,* 273: 122–130 (January) 1951.

[2] Pollack, Jerome: Kaiser-Frazer UAW–CIO Social Security Program, *Industrial and Labor Relations Review,* 6: 94–109 (October) 1952.

Edmund B. Whittaker, vice president of the Prudential Insurance Co., told the American Management Association that despite a phenomenal increase in the number of wage earners covered by group insurance, American businessmen must constantly review such programs to make sure that they provide the protection for which they were intended. Among the factors especially mentioned by Mr. Whittaker were the need for (1) increased hospital and surgical-medical benefits to cover rising costs, (2) realistic appraisal of the individual burden, and (3) more understanding between insurance carriers and the physicians and hospitals that furnish the service financed by insurance funds.[1]

A report of the committee on medicine in the changing order of the New York Academy of Medicine states that few plans provide anything like complete medical coverage for the entire family and that experience has shown that, even when it is offered, most people are unwilling or unable to pay the high premium required for such comprehensive care. The committee recognized the primary importance of extending the range of both services and coverage and advocated that, where employees of business or industrial organizations are involved, their families should be included and that coverage should be extended to include preventive and curative services in office, home, and hospital.[2]

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[1] Sees Need to Expand All Group Protection, *Eastern Underwriter,* November 24, 1950. P. 9.

[2] *Medicine in the Changing Order.* New York, The Commonwealth Fund, 1947. Pp. 203–204.

Section IV

Administration and Financing of Programs Under Collective Bargaining

Health and Welfare Clauses

Unions bargain for health and welfare programs in several different ways. Some agreements are negotiated with employers and others with employers' associations. Definitions of the following types of collective bargaining are contained in appendix 33: industrywide, industrywide on an area basis, areawide, employer associationwide, companywide, pattern, and local. A chart is presented in appendix 34 showing the employer structure for bargaining. Appendix 35 gives data on the percent of production workers under union agreements in 1946 covered by multiemployer agreements under industrywide, regionwide, and city or local area bargaining. Some national and international unions have developed a uniform plan and have attempted to have it written into local contracts; other nationals limit their activities to providing the locals with information and other types of assistance. Where industrywide plans have been established, the unions concentrate their efforts on bringing uncovered locals into the program and in arranging for identical benefits for all members.

Multiemployer Negotiations

The great increase in the number of industrywide and multiemployer negotiations is considered one of the most distinctive results of collective bargaining on welfare plans. Organization of a welfare plan on an industrywide or marketwide basis is said to be particularly useful where the employing units are small or it is common for workers to shift from one employer to another. It is a means of providing continuing benefit coverage on a realistic basis for workers who must look to industrywide employment. It also serves to bring the economies of group insurance on a large scale to small employing units and equalizes the cost of the program among a number of employers. However, negotiations of this type result in a number of distinctive problems, some of which have been briefly described as follows:[1]

1. A trust agreement must be worked out governing the organization and powers of the board of trustees.
2. The composition of the employee group must be canvassed in order to provide a basis for estimating the cost of various benefits.
3. A plan of benefits must be decided upon, bearing in mind the composition of the employees, their various needs and desires, and the relation of such a plan to any preexisting benefit systems.

[1] Tilove, Robert: Recent Trends in Health and Welfare Plans. In *Proceedings of the New York University Third Annual Conference on Labor.* (Emanuel Stein, Editor). New York, The University, 1950. Pp. 153–157.

4. A system must be created and effectively maintained for receiving, checking, and policing employer contributions. . . .

5. Rules of eligibility for benefits must be worked out and a system created for determining the status of individual claimants. . . .

6. An insurance carrier must be selected, if the benefits are to be insured. This has sometimes been done apparently in a rather haphazard manner; in other cases it has involved very careful shopping. Care and knowledge in this phase make a significant difference. In a recent case on which several carriers bid, involving almost a million dollars of annual premium, one company predicted that it would retain roughly 17 percent; another predicted that it would retain roughly 5 percent.

7. If an insurance contract is involved, its details must be worked out. This sort of coverage, where the policy holder is an industrywide board of trustees, is relatively new. There are insurance carriers to which this is an entirely new class of business. . . .

8. If the fund is to be self-insured, its rules and regulations must be worked out, actuarial projects prepared, and appropriate reserves created against the contingencies of the risk. . . .

9. Reserves must be determined against the possibilities of economic adversity. . . . Reserves must also be invested if the fund is to realize maximum income. Trustees should know enough either to direct investments or to fix intelligent policy on investment.

10. The role of the fund in the administration of benefits must be worked out. There are some cases in which the fund performs minimum functions, such as making claim forms available; in other cases it actually pays each of the claims by drafts drawn against the insurance carrier.

11. The relation of the fund to the legal obligations of the covered employers under disability insurance laws, in the States in which they exist, must be resolved.

A chart showing the extent of multiemployer bargaining (appendix 35) is included in a recent publication entitled *Contemporary Collective Bargaining*. The author, Harold W. Davey, states, "All the academic argument for and against multiemployer bargaining will not change the concrete fact that the trend in bargaining agreements is strongly in this direction. More inclusive bargaining units will probably become increasingly common because of strong pressures not only from unions but also from employers. It appears safe to conclude that over 30 percent of all workers covered by union agreements are working under agreements of the group employer type."

Health and Welfare Provisions

Bargaining agreements vary considerably in the extent to which they outline health benefits for which funds are to be allocated, the

amount of the funds often being the principal point considered. A few contracts go into considerable detail regarding the type of plan to be set up, but others are very general. In order that the programs may be flexible, some agreements create a union-management committee which is invested with power to investigate health programs and recommend a plan, to work out the details of the selected plan, and later to suggest modification as needed.

Some contracts also include such items as conditions regulating coverage, the appointment of a board of trustees, and provisions for collecting and compiling statistics, for settling disputes, and for adjusting the plan to possible future legislation in the health field.

In an analysis of union agreements received by the National Industrial Conference Board from September 1949 to April 1950, an attempt was made to determine the characteristics of the health insurance provisions included in the contracts. The wording, however, was frequently so vague that it was impossible to determine either the types of benefits to be included or the extent to which the employees share in the cost of the program. Moreover, even where the health program was outlined in considerable detail, important features were sometimes missing. For example, only about a third of the 503 union agreements referred in any way to the subject of insurance (appendix 36). Nevertheless, this represents a distinctive change over the situation in 1948, when a similar survey of 373 union agreements revealed that less than a fifth of them contained group insurance provisions.

In the 178 contracts that contained some type of insurance clause, in the later study, the provisions varied considerably (appendix 37); about one-third of the contracts incorporated the text of the entire insurance programs. In 109 contracts, information regarding benefits was detailed enough to be analyzed (appendix 38).

Administration

The agreement usually provides for separate administration of the health fund established under the contract and of the plan which results, but sometimes the two are combined. Under the terms of the Taft-Hartley Act, funds set up to handle sums appropriated for health programs after January 1, 1946, must be administered by boards with equal representation from union and management and must provide for settlement of deadlocks by some neutral party. Funds established prior to that date are administered in other ways: (1) by union representatives only, (2) by union and employer representatives, or (3) by union, employer, and some outside community group or agency.

Active participation by employers in program administration depends to a large extent on union-management relations in a particular plant or industry. Often, it is limited to the joint administration of the health funds through which the medical care benefits are financed. It is important that both management and labor work together to appraise current programs carefully and to develop objectives upon which to base contract negotiations, administrative policies, and cooperative arrangements with members of the health professions and representatives of other community health groups.

One plan covering a large group of workers which has operated for 5 years under a board of trustees composed of equal representation from management and labor is the Kaiser-Frazer UAW–CIO social security and retirement programs. Previously, the employee benefit plan in operation from 1946 to 1948 had been administered by the company and the insurance carrier. But in the collective bargaining agreement concluded on June 1, 1948, a joint board of trustees, with equal representation from labor and management, was constituted and assigned responsibility for developing and administering the program.

A consultant for the program, summarizing the benefits of this joint administration, said, "The agreement created a new framework for employee benefit planning in the industry. . . . The assurance of a substantial employer contribution made it possible to apply higher standards of adequacy in selecting benefits than ever before in the industry. Under the new program, the board of trustees as policyholder could receive any dividends and use them to provide additional benefits. Not only were costs brought out into the open, but, for the first time, a health plan was developed with primary concern for meeting employee needs, instead of the usual haphazard purchase of ready-made benefits." [1]

A well-planned, well-administered program that provides care of high quality is important to management and labor. On the other hand, poor planning may bring dissatisfaction to both. The tripartite panel on health, welfare and pension plans, for example, warned against inadequate programs in its report to the Wage Stabilization Board, by stating that they can promote dissatisfaction and unrest as great as or greater than that resulting from no plan at all.

Method of Financing

Employer financing of benefit programs under collective bargaining agreements may take either of two forms. The agreement may provide for employer contributions based on a given percentage of the

[1] Pollack, Jerome, *op. cit.*, p. 97.

payroll or a flat amount per worker, or it may specify that certain benefits will be provided without reference to their cost.

Under "funded plans" contributions are placed in funds from which benefits are paid directly or from which insurance is purchased. Reports indicate that industries with a large number of small employed groups have found these funded plans feasible and, in some instances, the only possible type of program that could be put into effect, since many States require a minimum number of individuals to be covered before a group policy is issued. The funded method is said to be almost a necessity if employees are to obtain continuous coverage in industries in which there is a high degree of mortality among employers or a high degree of mobility of the working force. In some cases the policies have been written by insurance companies established by the union itself.

Funded plans are often administered by trustees who are empowered to collect contributions, purchase specified types of benefits, and invest funds not required for current expenditures. Fund money and records are kept separate from those of the union, with neither employers nor unions having any right, title, or interest in or to the trust estates, except the right of the covered union members or their beneficiaries to the benefits provided. The administrative procedure of several funded programs recently studied by the department of economics and social institutions, Princeton University, is as follows:[1]

> *Sheet metal workers fund and folding box fund:* In these two plans equal numbers of union and employer representatives serve as cotrustees. The employer trustees represent the associations whose members are under contract with the locals. Should deadlocks over policy decisions occur, the two trust agreements provide for arbitration by a third party appointed by the mayor of New York City.
>
> *New York hotel trades funds:* The board of trustees consists solely of members of the executive board of the New York Hotel Trades Council, but employers are represented by a nine-man advisory committee which gives approval to the board of trustees before any disposition is made of property forming part of the principal of the trust estate, before any investments are made in securities other than those issued by the United States Government, and before any insurance contract is entered in or changed. With respect to all policy decisions the board of trustees and the employers' advisory committee vote as separate bodies. A majority of each body is needed to ratify a proposal. The trust agreement does not provide for arbitration should the parties become deadlocked unless a deadlock occurs after the employers are no longer required to contribute to the fund and termination or liquidation of the trust estate is being considered.

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[1] Slavik, Fred: *The Operation of Sickness Benefit Plans in Collective Bargaining,* Princeton, The University, 1951. Pp. 22–38.

Cooks, pastry cooks and assistants fund, and upholsterers international fund: Employers play no part in the administration of these two funds. In each plan the social security department of the union acts as trustee in handling the employers' contributions. Two-thirds of the contributions were immediately paid to the insurance company for the purchase of accidental death, weekly accident and sickness, and hospitalization and surgical insurance. The balance is retained to pay death benefits and to cover costs of administration. Since July 1, 1947, the social-security department of the unions has turned over the entire 3 percent payroll contribution to one and later two insurance companies. Reimbursement for administrative expenses incurred by the social security department is included in the "experience rating refund" returned by the carriers at the end of the policy year. The department has the responsibility of handling any surplus from the refund.

United Hatters, Cap and Millinery Workers, local No. 8: The plan is administered by the union's executive board, with the local's secretary-treasurer acting as chief administrative officer. No formal trust agreement has been drawn up, but the union segregates the employers' contributions in a separate account which is used to pay only the insurance premiums and administrative expenses. The amounts and types of benefits to be provided, choice of insurance company, and reserve and investment policy are determined by the union, but the executive director of the employers' association must countersign all checks in payment of insurance premiums and administrative expenses. He does not, however, play any role in the plan's day-to-day operations, and rarely confers with the union officers concerning the program.

International Ladies' Garment Workers' Union: The union has established a welfare and health benefit department in its international office, the director of which is responsible to the general executive board. The director and his staff receive and analyze reports on the operation of the local funds, audit their financial records periodically, and administer the international union's rules and regulations dealing with welfare funds. Benefiits are paid directly from funds without having the insurance underwritten by commercial carriers or an insurance company of their own. Local autonomy is encouraged. The program contains about 90 local or joint board funds throughout the United States and a few miscellaneous plans under which employers provide benefits through policies purchased from insurance companies. The international office exercises a considerable degree of supervision over local and joint board plans. The constitution of the union requires that health and welfare funds be completely segregated from general union funds and be used only for specified welfare purposes and related administrative expenses. Investments are limited to securities approved by the general executive board. Bylaws of local funds must be approved by the international before becoming effective.

In non-funded plans, as contrasted with funded plans described above, the employers agree to purchase insurance themselves directly

from a carrier without an intermediary fund being set up. The plans are more likely to be found among large firms and among firms with low labor mobility. The employer's financial obligation under such programs may take several forms. He may spend a given sum, such as a specific amount per worker or a percentage of the payroll, or he may be required to provide specific benefits which are written into the collective bargaining agreement, regardless of the cost. Often, where a group insurance plan is already in operation, it is incorporated into the collective bargaining agreement.

The administrative procedures for several nonfunded plans reported upon in the Princeton study are as follows:

American Federation of Hosiery Workers: The program officially consists of numerous local and area plans but is, in effect, national in scope. The union negotiates a national labor agreement with the Full Fashioned Hosiery Manufacturers of America covering 36 mills employing 11,000 members. It negotiates additional agreements with one other employers' association and 45 independents covering 15,500 employees; these follow the national labor agreement closely. With few exceptions, policies are written by the National Casualty Co. and are partially reinsured by the Union Casualty Co. Choice of insurance company under the national labor agreement was made by a committee representing the union and the Full Fashioned Hosiery Manufacturers of America. The policy is held jointly by the parties.

Both the agreement and the insurance policy run concurrently for 2-year periods. Ninety days prior to the expiration of these agreements, the representatives of the employers' association and the union meet to decide on possible changes in the amount of the employer insurance payments under the collective agreement. The joint committee then decides on changes in the insurance policy which it will request from the carriers. The employers' association and the union receive periodic reports from the insurance company concerning benefits paid, loss ratios, and reserves. On the basis of these reports the joint committee negotiates with the carriers in regard to a new policy. Premiums are stated in terms of the percentage of the payroll which the employers are required to pay under terms of the agreement. Payments are made by employers to the carrier.

Textile Workers Union of America: Plans are negotiated and administered by local unions and groups of locals with individual employers and employer associations. Ninety percent of the plans are noncontributory. The international office has attempted to develop uniform benefit and administrative standards for its local plans, and although some headway has been made, progress in this direction is difficult due to a wide variety of economic and social conditions in the numerous industries under the union's jurisdiction, and the absence of industrywide bargaining. The international office has an insurance director who serves as advisor to locals on matters concerning their insurance programs. He conducts surveys of benefits obtained

by other unions and assists the locals in formulating their welfare demands. In some cases he participates in the collective bargaining negotiations themselves. The director has no direct responsibilities for administration of any of the local plans but is called upon for assistance when administration difficulties arise.

Eighty percent of the insured membership is covered by plans under which benefits are specified in the collective bargaining agreements, with the employer required to secure a group insurance policy incorporating these benefits. Except in a few instances, the union has no voice in selecting the insurance company or in the administration of the policy, which is held by the employer. In a few instances, payment is based on a percentage of the payroll or a flat amount per worker, and the employer purchases the best available policy, with representatives of locals frequently participating in negotiations between the employer and the insurance carriers.

United Hatters, Cap and Millinery Workers Union: The program is exemplified by a contract between Local 60 and the John B. Stetson Co. covering 2,800 employees in its Philadelphia plant. The present plan is an outgrowth of an old employee benefit program, which had consisted of a jointly financed mutual benefit association, employer-financed hospitalization insurance, and a contributory group life insurance policy. The company now purchases a single "package" policy; it pays about 70 percent of the gross cost, retains all dividends, and has agreed to bear any future increases in cost. The bargaining agreement does not list the benefits to be provided and does not mention the amount of employer or employee contributions, but refers to the separate booklet describing the plan. The union does not participate in negotiations with the insurance company, and the policy is held by the employer. The union, however, must give its consent before the policy can be changed. As is the case with most of the plans in the textile industry, the union plays almost no role in the plan's administration.

The Princeton study lists five basic standards of operation for assuring that a plan will be able to continue fulfilling the functions for which it was created:

Security.—Protection of assets of a plan against inherent financial risks or possible mismanagement.

Stability.—The ability of a plan to continue payment of established benefits regardless of fluctuations in its assets or income.

Flexibility.—Adaptability with a minimum of delay to changes in the economic, legal, and social environment in which it operates.

Administrative facility.—Administrative arrangements which lend themselves most easily to the attainment of a plan's objectives, and which minimize points of possible friction.

Economy.—The maximum protection that can be obtained from the available resources.

Nonfunded plans are said to have the fewest potential problems with respect to security, since the employer discharges his obligation by purchasing the insurance directly from an insurance company. The coverage is purchased on a pay-as-you-go-basis. Soundness is insured by choosing an insurance company that is able to bear the risk and meet its liabilities under all circumstances.

Funded plans necessitate the safeguarding of assets not paid out for benefits. Under such programs there is no requirement that those administering the fund spend the entire income for premiums or for benefits, and it is a comon practice to retain a certain portion of the funds for future needs. Under the Taft-Hartley Act, all funds established after January 1, 1946, must be trusteed and include employer representatives on the board of trustees. The act also specifies the purposes for which the trust estate may be used.

Extent of Financing

Annual employer contributions to nongovernmental pension and health and welfare funds, both those collectively bargained and others, increased over the past 20 years from $113 million to $3.4 billion. These payments which declined from $128 million in 1929, the last big "boom" year, to $103 million in 1933, increased to $169 million in 1936. They fell off after that date until 1940, but thereafter, and especially during World War II, they increased rapidly. Contributions almost doubled between 1943 and 1944; by 1947, they were four times as great as in 1943, and during the next 5 years they more than doubled in amount, reaching a total of $3.4 billion. Data on contributions for each year, 1929 through 1952, are given in appendix 39.

The degree to which employers should carry the responsibility for financing health and welfare programs recently has become a major issue in collective bargaining, and at present there is a growing tendency for benefits to be financed entirely by employers. Although the phrases, "employer financing" and "employer contributions" are commonly used, the employees regard the contributions as money which is theirs since it is provided in lieu of wages. It should be recalled that the amounts reported as payments by employers represent both the amount paid under collective bargaining agreements and contributions to other prepayment plans financed by employers alone or jointly by employers and employees. Employer payments for pensions and health and welfare programs during selected years were as follows:

Year:	Amount, in millions	Year:	Amount, in millions
1929	$128	1949	2,059
1935	129	1950	2,804
1940	170	1951	3,125
1945	881	1952	3,436
1947	1,585		

As the Department of Commerce points out, these figures do not take into consideration the decrease in dollar value, nor can they be used as a measure of the recurrent annual cost of plans now in operation, because of large contributions to cover the past service liability of older workers. Nevertheless, they do indicate the influence of collective bargaining on the provision of such benefits.[1]

The $3.4 billion paid in 1952 included employer payments for pensions as well as health and welfare plans. It is estimated that about $1.3 billion of the total contributed by employers covered health and welfare plans only, and that at least $750 million of this amount represented employer contributions for hospitalization, surgical and medical benefit plans.

These payments are part of total employer (exclusive of Government) contributions for social insurance and other supplements to wages and salaries which amounted to a total of $8.3 billion in 1952. There have been marked changes over the years, especially since the passage of the Social Security Act, in the total amount paid by employers for such items although, as figure 2 indicates, such payments since 1937 have represented a relatively stable proportion of wages and salaries; namely, from 4 to 5 percent of the total. In 1929, in contrast, such payments amounted to 1 percent of wages and salaries.

The proportion of the total supplements to wages and salaries represented by payments for pensions and health and welfare benefits also has varied over the years. Before contributions to unemployment insurance and old age (later old age and survivors) insurance were paid as provided under the Social Security Act, employer payments for private pension and welfare funds represented one-fourth to one-third of all employer supplements to wages and salaries. Between 1937 and 1942 they were less than one-tenth of the total. Thereafter they increased rapidly, representing 34 percent in 1947 and 42 percent in 1950 and 1952. Details on employer contributions, including those by government, for the various types of supplements to wages and salaries for the years 1929–52 are given in appendix 39.

The method of financing health and welfare benefits obtained under collective bargaining agreements is known for programs covering nearly 6.5 million workers in mid-1950. Of these, nearly 60 percent

[1] U. S. Department of Commerce, Bureau of Foreign and Domestic Commerce: *National Income: 1951 Edition, A Supplement to the Survey of Current Business,* p. 201 and *Survey of Current Business,* July 1953, p. 24. Washington, U. S. Government Printing Office.

SUPPLEMENTS TO WAGES AND SALARIES BY PRIVATE INDUSTRY
1929-1952

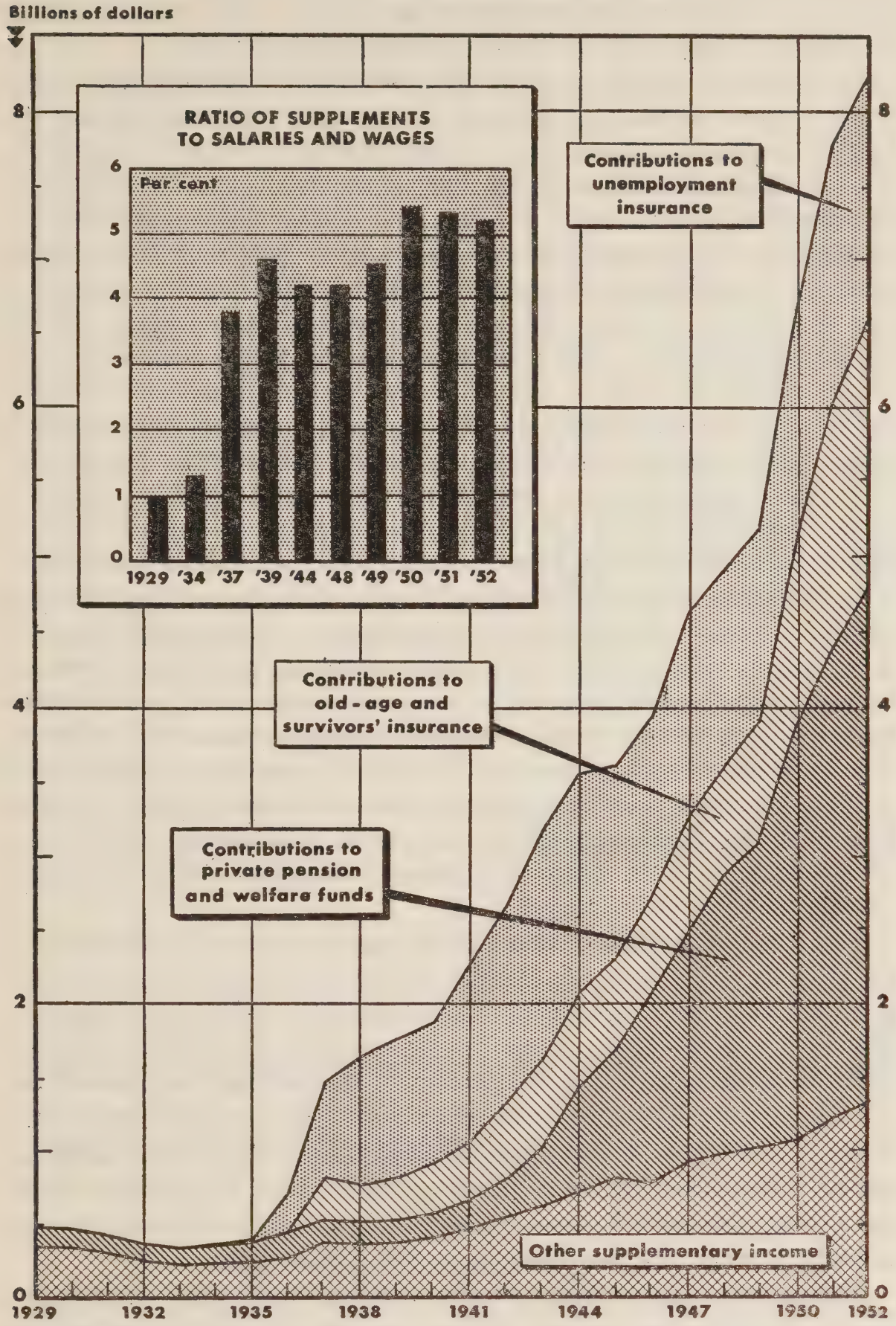

Figure 2.—Supplements to wages and salaries by private industry, and ratio of supplements to wages and salaries, 1929–52

Source: Based on U. S. Department of Commerce, Bureau of Foreign and Domestic Commerce: *A Supplement to the Survey of Current Business, National Income,* 1951 Edition, p. 201, and *Survey of Current Business,* July 1953, p. 24. Washington, U. S. Government Printing Office.

were covered by plans financed entirely by the employer. Of the unions for which data are available, about half had from 80 to 100 percent of their workers covered by health and welfare plans which were entirely financed by the employer (appendix 12).

The industry groups vary in the extent to which employers carry the entire cost of the health and welfare programs covered under collective bargaining agreements. In mid-1950, in the industry having the largest number of workers covered by some type of health and welfare plan, namely, metal products (including steel, automobile, and machinery), 15 percent of the workers were in programs financed entirely by the employer, 72 percent were in jointly financed programs, and 13 percent, in plans with unknown method of financing. In the textile, apparel, and leather industry, another group with large coverage, over 90 percent of the employees were in programs financed entirely by the employer. In transportation, communications, and other public utilities (excluding railroads), the industry group with the third largest coverage, over 70 percent of the employees were in plans financed entirely by the employer. The tendency since mid-1950 has been for the employer to assume a larger share of the cost.

In mid-1950, about 80 percent of the workers covered by any type of health and welfare program had protection against all or part of their hospital bill. Almost 65 percent of these workers were covered by programs financed entirely by the employer, and 35 percent were covered by programs jointly financed by employers and employees. About 72 percent of the workers covered by any type of health and welfare program had protection against either surgical or medical bills or both. A slightly larger proportion of those having this type of coverage were in programs financed entirely by the employer, namely, 71.5 percent (appendix 18).

To what extent do the existing programs meet the hospital and medical bills of those who are eligible for benefits? No information is available to answer this question as it applies to union members only. However, according to a recent Senate report, in 1949 Blue Cross hospital plans paid from 70 to 80 percent of the average hospital bill for all subscribers; during the same year, insurance companies paid from 45 to 55 percent of the average hospital bill for all policyholders enrolled under individual and group policies. Both Blue Shield medical society plans and insurance companies paid about 45 percent of the average total physicians' charges to their subscribers.[1]

Information also is lacking on the total amounts paid for hospital and medical services received by persons covered under collective bargaining agreements. It is known, however, that in 1951 over $1,352

[1] Committee on Labor and Public Welfare, U. S. Senate: *Health Insurance Plans in the United States (Report No. 359, part 1)*. Washington, U. S. Government Printing Office, 1951.

million was paid to hospitals, physicians, and other persons providing health services under all prepayment arrangements. About $897 million of this was paid for hospitalization; and $456 million, for services of physicians and other personnel. Blue Cross plans paid almost 50 percent of the total amount expended by voluntary insurance plans for hospital benefits; about 28 percent of the total were payments made under group commercial insurance contracts, and 13 percent, under individual insurance policies. The payments made under group contracts of commercial insurance companies represented the largest proportion of the $456 million (36 percent of the total) paid to physicians and other personnel, while the Blue Shield medical society program payments represent 32 percent of the total. About 12 percent was paid by commercial insurance companies under individual insurance contracts (appendix 40).

The Health Insurance Council has recently estimated that during 1952 $1,075 million was paid for hospital care and $546 million for surgical and medical care by all types of voluntary health insurance programs.[1] There was little change in the proportion of the total payments made by the different types of programs. As in the previous year, expenditures by Blue Cross hospital plans represented about 50 percent of the total expenditures by all plans for hospitalization. Payments made by insurance companies for surgical and medical coverage under group and individual policies represented 48 percent of the total, the same proportion of the total as in the previous year. Payments by the medical-society-sponsored plans represented a slightly larger part of the total expenditures for surgical and medical care, an increase from 32 to 34 percent. Estimated payments by each type of program during 1952 were as follows:

Item	Hospitalization	Surgical and medical care
Total	$1,075,000,000	$546,000,000
Insurance company contracts	437,000,000	261,000,000
Blue Cross and medical society sponsored plans	548,000,000	187,000,000
Other plans	90,000,000	98,000,000

[1] Health Insurance Council, Survey Committee: *Accident and Health Coverage in the United States.* New York, The Council, 1953. (In press.)

Section V

Eleven
Selected Programs

Local Programs Classified by Services

Summarized information

The following tables summarize some of the major characteristics of nine selected management- and labor-financed health and medical programs described in this section of the report. Each of these programs provides prepaid medical services on the basis of group medical practice at a health center. Beyond this common characteristic, the programs vary widely in scope of services offered, method of financing, organization, and other features.

Any summary of diverse programs necessarily glosses over differences since program characteristics cannot be readily presented in tabular form. There is the additional difficulty of lack of uniformity in the definitions used by the programs in recording costs and services provided. The summary tables should therefore be interpreted in the light of these inherent limitations. A detailed description of each of the nine programs will be found later in this section of the report. However, in order to make these summary tables more meaningful, some of the characteristics of the plans are briefly outlined here.

For the purposes of this comparison, the plans have been grouped in five broad classifications, depending on the scope of services offered. The least comprehensive plan provides only diagnostic services; the most comprehensive plan provides complete medical care as well as hospitalization and dental services. The plans may be briefly described as follows:

Group I—Diagnostic services

A. Health Institute of the United Automobile Workers, CIO, Detroit: Program was started in 1944; diagnostic services are provided for 350,000 Detroit United Automobile Workers members. Mental hygiene and optometric services are available in separate clinics. The center is financed by the union locals.

B. Union Health Center, International Ladies' Garment Workers' Union, Boston, Mass.: The center opened in 1949 to provide diagnostic and optometric services to union members in the Boston area. The program is financed from union health and welfare funds.

Group II—Medical care for ambulatory patients [1]

A. A. F. of L. Medical Service Plan of Philadelphia: Preventive services and medical care have been provided since 1951 at the center

[1] Plans are listed in order of size.

to members of affiliated locals and their dependents. All A. F. of L. unions in the Philadelphia area may affiliate with the plan; most locals finance the program from health and welfare funds. Starting with a membership of about 3,000, the plan by April 1953 had about 18,000 members.

B. The Sidney Hillman Medical Center of the Male Apparel Industry, Philadelphia: Preventive services and medical care are provided at the center, opened in 1951, to members of 16 locals and, in part of the industry, to dependent spouses as well. Operating costs are financed by funds obtained under collective bargaining agreements. Current membership is approximately 23,000.

C. The Sidney Hillman Health Center of New York: The center opened in 1951 to provide health and medical services to ambulatory patients. Members of 26 locals and their wives are eligible for benefits. The center operations are financed from per capita premiums paid by the 33,000 eligible persons and, since April 1953, from employer contributions.

D. Union Health Center, International Ladies' Garment Workers' Union, New York. Operating since 1913, the center now provides unlimited preventive services and medical care at the center to about 201,200 union members and limited services for their dependents. Services are financed by the locals from health and welfare funds.

Group III—Medical services at center and hospital

The New York Hotel Trades Council and Hotel Association Health Center, Inc., New York: The center was opened in 1950 to provide medical care to the 35,000 members of the New York Hotel Trades Council. All costs are paid from an industrywide health and welfare fund.

Group IV—Medical services at center, home, and hospital

Moving Picture Machine Operators' Union, Local 306 (administered through a pension and welfare fund): Members of the local and their wives receive comprehensive medical services through the Health Insurance Plan of greater New York. The local contracted with the health insurance plan in 1951 and at the end of the year had enrolled 3,555 persons. All costs are paid from the local's health and welfare fund.

Group V—Medical services at center, home, and hospital; dental care and hospitalization

Labor Health Institute, St. Louis: Program was established in 1945 by the union (now local 688 of the Teamsters, A. F. of L.); it provides comprehensive services to members and their dependents. All costs are paid from health and welfare funds negotiated by the local with the individual employers. During 1952, approximately 14,000 persons were enrolled in the plan.

Summary table 1 shows, for each of the nine medical programs, the broad categories of services provided and the average annual cost of those services for each eligible person. The annual cost per eligible person appears to be related not only to the scope of the services provided but also, within a given category, to the size of the membership. Of the 4 plans providing medical care to ambulatory patients, the plan with over 200,000 members reports a per capita cost of less than one-half the costs of 2 plans with similar services but with a membership roughly equivalent to 10 percent that of the larger plan.

The per capita costs represent all expenses of running the health centers, including depreciation charges and administrative and housekeeping expenses, as well as the costs of providing medical services. Where the center operates a pharmacy, any net cost of pharmacy operation is included. Costs exclude capital accumulation and, to the extent identifiable, expenditures made for services such as sick benefit certification.

It should be noted that the programs have different accounting systems and allocate costs in different ways. One program, for example, allocates a fixed percentage of total overhead costs to the pharmacy, while in another program the pharmacy is considered a completely separate operation. Similarly, depreciation charges are figured in different ways, and two plans make no charge for depreciation of the plant or equipment. Costs of special services, such as disability certification, preemployment examinations, and premembership examinations should be handled uniformly if the plans' financial data are to be comparable; however, in some cases there is no way of identifying these expenditures.

Only those services that are provided through the medical center program are listed. No inclusion is made of benefits covered under other union health and welfare programs, which in all cases cover hospitalization and in almost all cases, in-hospital surgical care.

The income of the plans is determined in one of three ways: (1) an annual per capita premium—4 programs are so financed; (2) a fixed percentage of the employers' payroll—3 programs are so financed; and (3) a cost basis, the center billing the local union for the approximate cost of services provided—2 programs are so financed. Premiums vary with the services provided and with the extent of reserve accumulation (summary table 2).

In general, the charge for dependent wives or husbands is the same as that for the union member. In the two plans covering other dependents, there is no extra charge for any dependents beyond the first in one plan, and beyond the second in the other plan.

The extent of coverage of dependents is presented in summary table 3. With the exception of the two diagnostic centers and one other program, all programs provide some coverage for dependent wives or husbands. The coverage of other dependents is, however,

Summary table 1.—*Selected management- and union-financed health and medical programs. Average annual cost per eligible person and type of service provided*

Program	Year	Average annual number of eligible persons	Annual cost per eligible person [1]	Type of service provided						
				Physicians' visits				Visiting nurse	Hospitalization	Dental Care
				Center or office		Hospital	Home			
				Diagnostic	Other					
United Automobile Workers Union, Detroit	1952	350,000	[2] $0.69	Yes						
International Ladies' Garment Workers' Union, Boston	1952	15,000	[3] 5.60	Yes						
AFL, Philadelphia	1951–52	6,038	14.26	Yes	Yes					
Sidney Hillman, Philadelphia	1951–52	22,712	14.77	Yes	Yes					
Sidney Hillman, New York City	1951–52	33,356	[4] 10.38	Yes	Yes					
International Ladies' Garment Workers' Union, New York City.	1952	201,200	6.27	Yes	Yes					
Hotel Trades, New York City	1952–53	[5] 34,762	16.79	Yes	Yes	Yes		[6] Yes		
Moving Picture Machine Operators' Union (through Health Insurance Plan), New York City.	1951	[7] 2,160	[8] 29.20	Yes	Yes	Yes	Yes	Yes		
Labor Health Institute, St. Louis	1951–52	14,606	[9] 49.84	Yes	Yes	Yes	Yes	[6] Yes	Yes	Yes.

[1] Includes any net cost of pharmacy operation, administration and depreciation charges. Excludes reserve accumulation.
[2] Excludes optometric services provided at cost in a separate clinic and excludes depreciation charges.
[3] Includes cost of sick-benefit certification.
[4] Excludes depreciation charges.
[5] Eligible persons for calendar year 1952.
[6] Minimum program developed to date.
[7] Equivalent in full years of coverage; approximately 3,500 different persons covered by the end of the year.
[8] Average annual cost per person (based on April 1953 experience), excluding statutory reserves, for all HIP enrollees.
[9] Includes about $7 per eligible person for dental services and $10.50 for hospitalization.
(Note: With the exception of members of a few local unions, all persons not having surgical care and hospitalization available through their clinic programs are eligible for such services through other health and welfare programs.)

Summary table 2.—*Selected management- and union-financed health and medical programs: Average annual premium*

Program	Period	Average annual number of eligible persons	Average annual premiums		
			Union member	Member and wife	Family
United Automobile Workers Union, Detroit	1952	350,000	[1]	----------	----------
International Ladies' Garment Workers' Union, Boston	1952	15,000	[2] $5.64	----------	----------
AFL, Philadelphia	1952–53	13,819	15.00	$30.00	$37.50
Sidney Hillman, Philadelphia	1951–52	22,712	[3] 15.00	NA	----------
Sidney Hillman, New York City	1951–52	33,356	10.00	20.00	----------
International Ladies' Garment Workers' Union, New York City	1952	201,200	[2] 6.27	----------	----------
Hotel Trades, New York City	1952	34,762	[3] 17.00	----------	----------
Moving Picture Machine Operators' Union (through Health Insurance Plan), New York City	1951	[4] 2,160	35.08	70.16	----------
Labor Health Institute, St. Louis	1951–52	14,606	[3] 60.00	[3] 130.00	[3] 130.00

[1] 18 to 30 cents per member plus an annual registration fee of $2 paid by each person registering for service at the institute.
[2] Income equals costs.
[3] Annual premiums equal to fixed percent of payroll; per capita premium payment is approximate.
[4] Equivalent in full years of coverage: approximately 3,500 different persons covered by the end of the year.

Summary table 3.—*Selected management- and union-financed health and medical programs: Coverage of dependents*

Program	Coverage of wives or husbands		Coverage of other dependents	
	Regular benefits	Benefits at reduced fees	Regular benefits	Benefits at reduced fees
United Automobile Workers Union, Detroit	----------	----------	----------	----------
Internation Ladies' Garment Workers' Union, Boston	----------	----------	----------	----------
AFL, Philadelphia [1]	Yes	Yes	Yes	Yes.
Sidney Hillman, Philadelphia [2]	Yes	----------	----------	----------
Sidney Hillman, New York City	Yes	----------	----------	----------
International Ladies' Garment Workers' Union, New York City.	----------	Yes	----------	Yes.
Hotel Trades, New York City	----------	----------	----------	----------
Moving Picture Machine Operators' Union (through Health Insurance Plan), New York City.	Yes	----------	----------	----------
Labor Health Institute, St. Louis [3]	Yes	----------	Yes	----------

[1] Dependents are covered for regular benefits by 5 out of 18 participating locals; other dependents may receive technical services at cost.
[2] Eligible Mar. 1, 1953 in the clothing industry; not yet eligible in cotton garment industry.
[3] Dependents of 94 percent of the union members are covered.

very limited. Only one program has full benefits for virtually all dependents; in one other program, dependents are covered for full benefits by about one-third of the participating unions. In several of the programs, however, plans are underway for more extensive coverage of other dependents.

The plans vary widely in the manner of staffing the medical departments. Some programs have a large number of physicians who serve only a few hours a week or who keep no regular hours at the clinic.

Other plans have several full-time physicians supplemented by a smaller number of part-time physicians.

The relative number of general practitioners and specialists also varies considerably among the plans. Three of the programs have no general practitioners; the work normally done by a general practitioner is performed by internists. In the other programs the number of general practitioners varies from less than 20 percent to nearly 60 percent of the medical staff. This, however, does not necessarily give a clue to the relative number of specialist and general practitioner hours, since the general practitioners are more likely to be on a full-time or half-time basis (summary table 4).

Excluding the diagnostic centers, the annual number of physicians' hours per 1,000 eligible members in 1951 or 1952 is estimated to have varied from a little over 300 to over 1,400. These are hours spent in actually seeing patients and make no allowance for administrative duties, study and research, vacations, and the like. The time spent by special consultants, not on the regular center staff, is not included in the estimated hours for some of the programs. The data, therefore, should not be considered an exact count but an approximation of the physicians' hours used in the various types of programs.

Summary table 4.—*Selected management- and union-financed health and medical programs: Number of physicians and physicians' hours per 1,000 eligible persons*

Program	Period	Average annual number of eligible persons	Number of full- and part-time physicians		Annual physicians' hours per 1,000 eligible persons
			General practitioners	Specialists	
United Automobile Workers Union, Detroit	1952	350,000	24	11	[1] 35
International Ladies' Garment Workers' Union, Boston	1952	15,000	----------	34	[1] 280
AFL, Philadelphia	1951–52	6,038	----------	30	683
Sidney Hillman, Philadelphia	1951–52	22,712	----------	48	[2] 653
Sidney Hillman, New York City	1951–52	33,356	27	54	556
International Ladies' Garment Workers' Union, New York City [3]	1952	201,200	67	85	317
Hotel Trades, New York City	1952	34,762	30	145	[4] 510
Moving Picture Machine Operators' (through Health Insurance Plan), New York City	1951	[5] 2,160	NA	NA	NA
Labor Health Institute, St. Louis	1951–52	[6] 14,203	10	[7] 32	[8] 1,441

[1] Estimated.
[2] Annual rate of hours scheduled in January 1953 divided by fiscal year 1952 enrollment.
[3] Excludes physicians and estimated physicians' hours devoted to sick benefit certification.
[4] Does not include (1) consultations with approximately 100 physicians who do not keep regular hours at the center or (2) hours at the hospital.
[5] Equivalent in full years of coverage; approximately 3,500 different persons covered by the end of the year.
[6] Members eligible for medical services; a small additional number of persons are eligible only for hospitalization.
[7] Excludes 5 associate physicians who make home, hospital and office calls in East St. Louis.
[8] Based on 1951–52 physician hours at the center and 1951 hours at hospital, home and doctor's office.

Summary table 5 gives data on the extent to which the membership of each plan used the services offered. In the plans providing medi-

Summary table 5.—*Selected management- and union-financed health and medical programs: Utilization of services*

Program	Period	Average annual number of eligible persons	Percent using service during year	Services per 1,000 eligible persons				
				Total [1]	Physicians' visits			
					Total	Center or office	Home	Hospital
United Automobile Workers Union, Detroit	1952	350,000	3	232	43	43	----------	----------
International Ladies' Garment Workers' Union, Boston	1952	15,000	25	1,569	605	605	----------	----------
AFL, Philadelphia	1951–52	6,038	28	3,847	1,754	1,754	----------	----------
Sidney Hillman, Philadelphia	[2] 1951–52	22,712	26	2,761	1,238	1,238	----------	----------
Sidney Hillman, New York City	[3] 1951–52	33,356	31	4,122	2,011	2,011	----------	----------
International Ladies' Garment Workers' Union, New York City	1952	201,200	23	2,360	1,200	1,200	----------	----------
Hotel Trades, New York City	1952	34,762	32	3,879	2,105	[4] 1,901	----------	[5] 217
Moving Picture Machine Operators' Union (through Health Insurance Plan), New York City	1951	[6] 2,160	[7] 70	NA	7,471	6,821	299	351
Labor Health Institute, St. Louis	1951–52	14,606	62	[8] 11,115	5,258	[9] 4,273	271	[10] 714

[1] Excludes pharmacy services.
[2] Data on services are for 51 weeks.
[3] Services per 1,000 are annual rates based on experience of 18 months; percent of members using based on experience of 50 weeks.
[4] Includes outside consultations.
[5] Estimated; assumes 1 visit per hospitalized patient per day, plus 1 additional visit for each hospitalized, surgical or obstetrical procedure. Includes emergency calls made to determine the need for hospitalization.
[6] Equivalent in full years of coverage; approximately 3,500 different persons covered by the end of the year.
[7] Data on percent using service are based on 10½-month period.
[8] Includes 3,626 dental services per 1,000 eligible members; excludes physiotherapy, home nurse visits and certain special procedures.
[9] Includes referral to physicians not on Labor Health Institute staff.
[10] Estimated; assumes 1 visit per hospitalized patient per day plus 1 additional visit for each hospitalized surgical or obstetrical procedure. Includes hospital consultation and outpatient visits.

cal care to ambulatory patients, from 23 to 31 percent of those eligible for service received care at the center during the year. Among the two plans providing services not only at the center but also at the hospital and home, there was remarkable similarity in the proportion of members who used the services. Fifty-eight percent of the moving-picture machine operators and their wives saw a physician during the first 10½ months the union was affiliated with the Health Insurance Plan. In St. Louis, 62 percent of the members and dependents covered for benefits used the services during a 12-month period.

Data on the number of services provided for each 1,000 eligible persons, also presented in summary table 5, show much less consistency. This variation may be attributed in part to differences in the scope of services offered and in part to differences in definition and in the manner in which services are counted. One plan, for example, may consider a "complete blood count" one service, while another considers it 4 services.

The greatest use of physicians' services occurred among the members of the Moving Picture Machine Operators' Union, who received services through the Health Insurance Plan of Greater New York. Their utilization (7,500 visits per 1,000 eligibles) was about 40 percent higher than that of the program with the next highest utilization (5,300 visits per 1,000) and nearly 50 percent higher than the utilization of all Health Insurance Plan enrollees. The Health Insurance Plan points out that three conditions probably played some part in the high utilization rate of the moving picture machine operators union enrollees. First, men in the older age groups are known to have higher utilization than younger men. Second, the union members were in the initial period of coverage, which often, though not invariably, has higher rates than obtain in later periods. Third, persons whose occupations leave them free to visit physicians during the early part of the day have been found to visit doctors more frequently than persons who either have to take time off during the day or who obtain medical service in the evenings after working hours.

For the programs which provided medical care only at the center, visits to physicians ranged from about 1,200 per 1,000 members to approximately 2,000 per 1,000 members.

Health Institute of the UAW-CIO*

7930 East Jefferson Avenue

Detroit, Michigan

This is a diagnostic center set up in Detroit, Mich., primarily to provide diagnostic medical services for work connected illnesses to approximately 350,000 members of the United Automobile Workers of the CIO. The center is financed by per capita contributions from the locals. During 1952 approximately 11,000 persons visited the center. The average cost of diagnostic services was about $22.00 per patient. Not included in this cost are mental hygiene and optometric services offered in separate clinics.

In 1943 the United Automobile Workers established in Detroit a Medical Research Institute which was incorporated in March 1944, as the Health Institute of the UAW–CIO. The center grew out of the union's concern with occupational disease and their belief in the importance of health education and improvement of safety conditions in the plants.

Basic objectives outlined by plan

Development of the concept of health as a positive attribute. The program calls for ". . . labor's full participation in the extension of preventive medicine and methods for the elimination of industrial disease and accident hazards as well as methods for the improvement of the health of the workers in the community."

Eligibility

Any member of a United Automobile Workers Local in the Detroit area which is affiliated with the health institute is eligible for diagnostic services. (With very few exceptions, the locals have affiliated with the Institute.) Union members' dependents are not covered. United Automobile Workers locals and other unions which are not affiliated with the health institute may secure services for their members by payment of an examination fee. Services of the mental hygiene clinic are available to all union members and other adults 18 years of age or over in Detroit and the metropolitan area. Optometric services are available only to members of the United Automobile Workers.

*J. A. Katzive, M. D., Director, Health Services Division.

Membership

The membership of the United Automobile Workers in the Detroit area was approximately 350,000 in 1952; members had an average weekly income of $81.76.

Method of financing and cost of care

Method of financing.—Local unions pay the health institute a monthly per capita assessment varying from 1½ to 2½ cents. In addition, a registration fee of $2 is charged each person registering at the institute. This fee entitles him to diagnostic and consultation services for 1 year. For union members who are not members of the affiliated locals, the Institute charges $25 for a diagnostic examination.

No charge is made for services at the mental hygiene clinic, which is financed by the Community Chest and the International Union. The eye clinic is self-supporting; a charge of $3 is made for each eye examination and glasses are provided at cost.

Operating costs.—Total costs of operating the institute in 1952 were about $379,000. Expenditures of the medical department for diagnostic services—including laboratory procedures and X-ray examinations and consultations—were about $243,000. Costs of the eye department were about $80,000 and of the mental hygiene department, $37,000. Expenditures do not include any reserve for depreciation of the building and equipment but represent actual cash outlays.

Department:	*Expenditures*
Medical	$243,242
Professional fees and salaries	145,294
Supplies	27,000
Other	70,948
Eye	80,000
Mental hygiene	37,000

Average cost per patient.—For each patient registering at the institute for diagnostic medical services, the average cost was $22.07 during 1952.

Payments to physicians

Part-time general examining physicians are paid at an hourly rate ranging from $4 to $7.50. Total payments to physicians during 1952 were $83,364. Physicians associated with the medical department received $77,124; optometrists in the eye department received $16,000, and the psychiatrists on the staff of the mental hygiene department received fees of $6,240.

Services provided

Medical diagnostic services.—Appointments at the diagnostic clinic are arranged through the local union offices. Each patient is seen first by a registration clerk who takes a detailed occupational and personal history. The patient is then given routine laboratory work and is seen by a general physician who prepares a medical history, does a complete physical examination and arranges for any additional

laboratory procedures, diagnostic X-rays or consultations with specialists which he considers necessary. Specialities are: general medicine including cardiovascular and gastro-enterology; psychiatry; neurology and neurosurgery; dermatology and syphilology; eye, ear, nose, and throat; orthopedics; general surgery; gynecology; urology.

Should further medical care be indicated, the patient is referred to his personal physician. If he has no personal physician, he is given a list prepared by the health institute, with the advice of the county medical society or other qualified physicians.

The eye department provides eye examinations and prescriptions for glasses.

The mental hygiene department offers diagnostic and therapeutic psychiatric service to persons who present medical or employment problems that have a social, emotional or psychiatric basis. Most patients are referred from the medical department by the examining physicians. Referrals are also taken from other health agencies, as well as from labor and management sources.

Ancillary services.—Standard laboratory procedures and diagnostic X-rays are made in connection with establishing medical diagnoses.

Cooperative services.—The institute places special emphasis on education in health and safety in cooperation with the union's department of Industrial Health and Safety. The program is carried out in the plants, and at the institute, through special courses and through distribution of education materials. Group examinations and plant inspections are made where special industrial hazards are thought to exist.

The results of all examinations and laboratory studies are available to the patients' physicians upon their request and with the approval of the patient.

Other medical services.—Eyeglasses are provided at cost.

Services not provided.—Institute gives no medical treatment.

Facilities

The institute owns and occupies a three-story building in Detroit. The building has 15,386 square feet, including a central waiting room, 13 examining rooms, X-ray and laboratory equipment, a small technical library, and necessary office space for clerical help.

The institute is open from 9 a. m. to 5 p. m. on Mondays, Wednesdays, and Fridays; and from 9 a. m. to 7 p. m. on Tuesdays and Thursdays.

Staff

Administrative staff.—The institute has an administrative staff of 18, including a full-time medical director.

Professional staff.—The medical department is staffed by 35 part-time physicians, including 24 general physicians and 11 specialists. In addition, there are 1 registered nurse, 1 practical nurse, 4 laboratory technicians, and 3 X-ray technicians. The eye department has 2 full-time optometrists on the staff; the mental hygiene department has 3 case workers and the equivalent of 1 half-time psychiatrist.

Qualifications for physicians.—Physicians are selected by the medical director. General physicians are required to have 3 years' experience either in private practice or as residents. Specialists are required to be Board certified.

Physicians' hours.—Approximately 250 physicians' hours are scheduled each week at the institute; more than 75 percent of the hours are in general medicine. See table 1 for the number of physicians on duty each day and the average number of hours scheduled each week by specialty.

Table 1.—*Weekly time schedule of physicians' hours at health institute of UAW–CIO*

Department	Total scheduled hours per week	Number of physicians	Physicians on duty				
			Monday	Tuesday	Wednesday	Thursday	Friday
General medicine [1]	A. m.—63 P. m.—104 Evenings—24.	A. m.—21 P. m.—26 Evenings—12.	A. m.—3 P. m.—6	A. m.—5 P. m.—6 Evenings—6.	A. m.—5 P. m.—4	A. m.—3 P. m.—5 Evenings—6.	A. m.—5. P. m.—5.
Psychiatry	A. m.—12 P. m.—4	A. m.—4 P. m.—1	A. m.—1	A. m.—1	A. m.—1	A. m.—1 P. m.—1	
Neurology and neurosurgery.	--- P. m.—6	A. m.—0 P. m.—1	--- ---	--- P. m.—1	--- ---	--- ---	
Dermotology and syphilogy.	A. m.—2 P. m.—6	A. m.—1 P. m.—1	A. m.—1 ---	--- P. m.—1	--- ---	--- ---	
Eye, ear, nose, and throat.	A. m.—3 P. m.—4	A. m.—1 P. m.—1	--- ---	--- ---	--- ---	A. m.—1 P. m.—1	
Orthopedics	--- P. m.—2	A. m.—0 P. m.—1	--- ---	--- ---	--- P. m.—1	--- ---	
General surgery and gynecology.	A. m.—6 P. m.—12	A. m.—2 P. M.—2	A. m.—1 ---	--- P. m.—1	--- ---	A. m.—1 ---	P. m.—1.
Urology	A. m.—3 ---	A. m.—1 P. m.—0	--- ---	--- ---	--- ---	--- A. m.—1	

[1] Includes cardiovascular and gastrointestinal clinics.

Source: Health Institute of UAW-CIO, Detroit, unpublished data.

Utilization

Persons receiving care.—In 1952, 11,019 different persons (including about 100 to 125 persons who were not members of the affiliated locals) visited the institute for diagnostic services. This represented about 3 percent of the United Automobile Workers Detroit membership. There were 4,950 persons who visited the eye department and 1,203 individuals who used the mental hygiene department. It is probable that most of the persons visiting the eye and mental hygiene departments also received diagnostic services.

Total services provided.—The 11,109 persons receiving diagnostic services made 15,032 physician visits, about 1.4 visits per patient.

Most persons did not require consultations with specialists but were taken care of by the general practitioner. Each person saw the general practitioner once and approximately 4,000 specialty consultations were given, nearly one-half of them being in general medicine or eye, ear, nose, and throat. The number and type of specialty consultations is shown in table 2.

Table 2.—*Diagnostic visits to physicians, Health Institute of the UAW–CIO, Detroit, 1952*

Specialty	*Number of visits*
Total visits	15,032
General practitioners	11,019
Specialty consultation	4,013
General medicine including cardiovascular and gastrointestinal clinic	1,210
Psychiatry	224
Neurology and neurosurgery	325
Dermatology and syphilology	398
Eye, ear, nose, and throat	702
Orthopedics	501
General surgery and gynecology	192
Urology	461

Source: Health institute, UAW-CIO: Unpublished data, April 1953.

Patients received more than 45,000 laboratory procedures; nearly every patient had at least one serology, blood and urine test. Chest X-rays were given to each patient and represented more than one-half of the 21,000 X-ray examinations given. Detail on laboratory and X-ray procedures is continued in table 3.

Table 3.—*Laboratory procedures and X-ray examinations, Health Institute of the UAW–CIO, Detroit, 1952*

Procedure	*Number of procedures*
Laboratory procedures:	
Total	45,437
Serology	10,970
Blood	16,190
Urine	13,795
Stool	635
Electrocardiogram	2,867
Basal Metabolism	498
Miscellaneous	482

Source: Health Institute, UAW-CIO; unpublished data, April 1953.

Procedure	*Number of procedures*
X-ray examinations:	
Total	20,869
Barium enemas	339
Chests	11,142
Fluoroscopy	1,165
Gall bladders	797
Gastrointestinal	825
Kidney, ureter, and bladder	464
Pyelograms	345
Sinuses	493
Skeletal structure	4,863
Skulls	436

The mental hygiene department had 1,444 visits, an average of 1.2 visits per patient. This does not include 224 consultations with psychiatrists which are counted in the 4,000 specialty consultations under the medical department. The eye department made 4,950 refractions and sold 4,724 pairs of glasses.

Administration

The board of trustees, composed of five members of the International Union, sets board policy. A medical advisory council consisting of physicians and engineers assists in establishing governing policies. There is a labor consultative committee of representatives of organized labor that meets to discuss policy and further needs of

union members. The medical director coordinates the services and activities of the institute.

OTHER HEALTH AND WELFARE BENEFITS

Financed by employer or jointly by employer and employee, depending on the local's contract.

Hospital care.—Through Blue Cross and other nonprofit service plans, and through group insurance. Provides up to 120 days in semiprivate accommodations, use of operating room, drugs, laboratory services. Dependents are usually covered.

Medical-surgical care.—Provided through Blue Shield, other nonprofit medical service plans, and group insurance. Medical and surgical services in the hospital. Dependents are covered by most contracts.

Life insurance.—The average worker is insured for $3,200 until retired and for $500 to $2,000 for the rest of his life. (During 1952 average benefits of $3,100 were paid to the families of persons who died in 1952.)

Temporary disability.—Most United Automobile Workers are eligible to receive $35 per week for up to 26 weeks.

Retirement.—Average monthly retirement pension of all members in 1952 was $41 from pension trust funds. This is in addition to an average of $82 from old-age and survivors insurance.

Permanent total disability.—All United Automobile Workers pension plans include such benefits. Income varies from $50 to $120 per month for employees who meet specified eligibility requirements based on age and length of service. The age requirement varies from none at all to 55 years; required years of service range from 10 to 25 years. The benefits are payable to age 65, when the normal retirement pension becomes effective. Additional disability benefits have been added to some life-insurance contracts, but, in these cases, payments made for disability reduce amounts of survivors' benefits; in a few instances a residual amount of $500 is earmarked for survivors.

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Union Health Center*

International Ladies' Garment Workers' Union

33 Harrison Avenue

Boston, Massachusetts

This is a diagnostic group clinic which opened on May 15, 1949. It provides diagnostic and optometric services to about 15,000 members of the International Ladies' Garment Workers' Union (A. F. of L.) in and around Boston. Dependents are not included. It is financed from union health and welfare funds obtained under collective bargaining agreements. Operating costs for the program, including sick benefit certification, in 1952, were about $5.60 per person eligible for services.

The wartime controls, limiting wage increases but permitting certain types of fringe benefits, stimulated the locals to secure employer-financed health and welfare funds. In 1944 the International Ladies' Garment Workers' Union convention adopted a resolution urging unions to bargain for pooled health and welfare funds.

Basic objectives outlined by plan

The center was set up to give the following four types of examinations:

1. A complete annual diagnostic examination.
2. An annual eye examination.
3. Special procedures at the request of the family physician.
4. Examination for certification of sick-benefit claims.

Eligibility

All members of the 26 International Ladies' Garment Workers' Union locals in the Boston area are eligible for the diagnostic and optometric services at the center. Members must have belonged to the local for six months. Dependents do not receive benefits.

Membership

There were approximately 15,500 ILGWU members during 1952, an increase of about 3,000 over 1950.

Most members work in small shops and the industry is characterized by seasonal employment.

Method of financing and cost of care

Method of financing.—The building which houses the center was purchased jointly by the Boston joint board and the northern New

*Philip Kramer, President and Chairman, Board of Trustees; Mary Levin, Treasurer; Joseph H. Kaplan, M. D., Medical Director.

England district council in 1947 for $315,000. The space used by the center was equipped and air conditioned at a cost of $173,000. Funds for purchasing and equipping the building were contributed by the locals.

The health center operation is financed from the locals' health and welfare funds secured under collective bargaining agreements. Employer payments to the funds equal 2 percent of payrolls. The health center receives from the locals amounts equal to approximate costs.

Operating costs.—Costs of operating the health center were about $75,000 in 1952. Physicians' fees and salaries of ancillary personnel represented about 55 percent of the operating costs.

Item	1952	Item	1952
Total	$74,685	Medical supplies and equipment	7,571
		Administration	7,418
Staff physicians' fees	28,702	Depreciation	3,336
X-ray consultant	2,183	Other	14,657
Salaries, ancillary personnel:			
Nurses	3,807		
X-ray and laboratory technicians	7,011		

Average cost per member.—The average annual cost per member in 1952 was $5.64 including the cost of sick-benefit certification.

Among the locals the cost per member-patient ranged from $8.96 to $32.66.

Payments to physicians.—During 1952 physicians on the staff of the health center received $28,702 and a consulting radiologist received payments of $2,183. Physicians are paid on an hourly basis; the minimum hourly rate is $7.

Services provided

Diagnostic and optometric services are provided at the health center. Services are available only by appointment. The findings are sent to the patient's personal physician if medical treatment is indicated or if the services were provided on the physicians' request.

Diagnostic services.—Each patient is seen by an internist who is responsible for requesting any special procedures and who summarizes the recommendations and makes the final report. The standard diagnostic examination, given annually at the patient's request, includes:

Complete history and physical examination by internist.
X-ray examination of chest, 14 by 17 film.
Urinalysis.
Complete blood count.
Sedimentation rate by Westergren method.
Blood serology.

In addition consultations may be requested by the internist in any of 11 other specialties: radiology, surgery, orthopedic surgery, thoracic surgery, gynecology, proctology, urology, ophthalmology, dermatology, neuropsychiatry and otolaryngology.

Eye examinations are provided annually at the request of the patient.

If no abnormal findings are present a note to that effect is mailed to the member, but if abnormal findings necessitating treatment are present, these together with all the recommendations are sent to the family physician for his disposition. At the same time a note is sent to the member indicating that a condition is present which requires treatment and that the findings have been forwarded to his doctor. In the event that the patient has no family physician, a letter is sent to that individual indicating the necessity of selecting a physician.

Ancillary services.—The internist may request any procedures, in addition to those contained in the standard examination, necessary to complete the diagnosis. Such special procedures include X-rays, basal metabolism, electrocardiograms, audiometer tests, blood chemistries, examination of sputum, feces, gastric contents, and special smears.

Cooperative services.—Upon the request of the family physician a member may have any laboratory procedure, X-ray examination or consultation. A report of the findings is sent to the family physician.

Other medical services.—The by-laws of the health and welfare funds indicate that each member applying for sick benefits shall be examined at the discretion of the medical authority.

Glasses are provided at special rates; members receive $5 for lenses through the union's health and welfare program.

Transportation costs for two trips paid only to members who reside outside greater Boston (35 to 100 miles).

Services not provided.—No medical treatment is given.

Facilities

The center occupies 6,500 square feet in the eight-story building owned jointly by the Boston joint board and the northern New England district council. The building is in the center of the garment district. There are six double examining rooms and special rooms for services in otorhinolaryngology, ophthalmology, gynecology, urology and proctology. The available diagnostic equipment is comparable to that of a small hospital.

The health center is open all day, on Mondays through Fridays, and some medical personnel is on duty, but the actual clinic sessions are from 5 p. m. to 7:30 p. m. daily except Wednesday and from 10 a. m. to 12:30 p. m. on Saturdays except for every other Saturday when the sessions run from 9 a. m. to 2 p. m. These hours are selected to minimize time lost from work. The rest of the day is used for special procedures and examinations.

Staff

Administrative staff.—Includes a full-time executive director, a part-time director of public relations and 3 medical secretaries, 2 of whom are full time.

Professional staff.—Includes a part-time medical director who averages about 20 hours a week. There are 34 part-time physicians including 11 internists and 23 physicians representing 11 other specialties.

In addition to the staff physicians, the center employs a clinic supervisor who is a full-time registered nurse and who is responsible to the medical director for the coordination of all the clinic activities; a part-time registered nurse; a full-time X-ray technician; a full-time laboratory technician; and a part-time attendant who assists the supervisor.

Physicians' hours.—Generally three internists are present during each clinic session and the other specialties are scheduled for varying numbers of sessions depending on the demand. A regular clinic session is 2½ hours with a double session on alternate Saturdays. See table 1 for a schedule of clinic sessions.

Table 1.—*Total number of scheduled hours and number of physicians on duty each week, Union Health Center, Boston, 1952*

Department	Total scheduled hours [1]	Number of physicians	Number of physicians at center					
			Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Internal medicine	40	11	3	3	----	3	3	3
Eye	10	4	1	----	----	1	1	1
Gynecology	8–10	5	1	----	----	1	[2] 1	1
Proctology	2½	2	----	1	----	----	----	----
Ear, nose, and throat	5	3	1	----	----	1	----	----
General surgery	2½	1	----	----	----	1	----	----
Orthopedic surgery	2½	2	1	----	----	----	----	----
Urology	0–5	2	----	----	[3]	----	[2] 1	----
Neuropsychiatry	2½	1	1	----	----	----	----	----
Radiology	5	1	----	1	----	1	----	----
Thoracic surgery	[3]	1	----	[3]	----	----	----	----
Skin	2½	1	----	----	----	----	1	----

[1] Estimated. Assumes each physician is present for full session, 2½ hours, except on alternate Saturdays when internists' sessions run for 3½ hours.
[2] Scheduled on alternate weeks.
[3] When necessary physician comes in for session.

Source: Union Health Center: Boston, 1953. Unpublished data.

The internists see about 4 new patients during a session. The average number of patients seen by other specialists ranges from 4 to 14.

Average number of patients seen during each regular clinic session by specialty is listed below.

Specialty	Average number of patients per session
Internal medicine	[1] 4
Radiology	[2] 5
Surgery	Up to 8
Orthopedic surgery	5–8
Thoracic surgery	[3]
Gynecology	6–14
Proctology	4–7
Urology	5–7
Ophthalmology	8–12
Dermatology	4–8
Neuropsychiatry	4–6
Otolaryngology	6–8

[1] New patients.
[2] Fluorograms taken and read.
[3] No regular sessions.

Qualifications for physicians.—Physicians are selected by the medical director. Specialists are required to be board certified or have equivalent qualifications.

Utilization of services

Persons receiving care.—From the time the health center opened through December 1952 (43½ months), 6,194 members have used the center. During the calendar year 1952, 3,843 members or 24.7 percent of the eligible persons received diagnostic services. Sick benefit certifications were made for an additional 49 members.

Total services provided.—During the time the health center has been in operation, the 6,194 patients have made 29,561 visits to the center and received 79,956 services. Each patient made, on the average, 4.8 visits and had 12.9 services. During 1952, the 3,843 patients received 23,534 diagnostic services, 1,570 services per 1,000 eligible persons.

Services provided by medical departments.—During 1952, patients made about 9,070 visits to physicians, or about 605 visits per 1,000 eligible persons. Of these visits, 5,100 were to specialists other than the center's internists. Of the 5,102 referrals to specialists, visits to the gynecologists and eye specialists each accounted for more than 10 percent of the total. Table 2 shows for the years 1949–52, the number of referrals to each specialty.

Table 2.—*Number of patients referred to specialists, Union Health Center, Boston, 1949–52*

Specialist	1949	1950	1951	1952
Total	2,598	3,984	4,843	5,102
Allergy	24	16	19	22
Dermatology	136	144	203	176
Eye	931	1,533	1,623	1,696
Gynecology	514	1,084	1,472	1,679
Neuropsychiatry	89	122	191	171
Ear, nose, and throat	370	463	449	447
Orthopedics	157	257	299	312
Proctology	132	134	194	240
Surgery	172	165	237	224
Thoracic surgery	----	----	5	45
Urology	73	66	151	90

Source: Union Health Center: Boston, 1953. Unpublished data.

Services provided by ancillary departments.—The center made nearly 3,700 X-ray examinations during 1952 in addition to about 400 fluoroscopies. Chest X-rays, included as part of the initial examination, accounted for about 75 percent of all X-rays. The laboratory department did about 10,000 laboratory procedures during the year. Ancillary procedures are shown in more detail in tables 3 and 4.

Administration

The three directors outline the policies of the center, subject to the approval of the two-member board of trustees. The directors are the executive director (primarily responsible for the business admin-

Table 3.—*Number and type of X-ray services, Union Health Center, Boston, 1952*

Type of service	Number	Number per 1,000 eligible persons	Type of service	Number	Number per 1,000 eligible persons
Total X-rays	4,413	294.2	Gastrointestinal	231	15.4
			I. V. pyelograms	52	3.5
Barium enema	113	7.5	K. U. B	47	3.1
Bone	382	25.5	Sinus	58	3.9
Chest	2,713	180.9	Skull	38	2.5
Fluorograms	389	25.9	Spine	195	13.0
Gallbladder	169	11.3	Miscellaneous	26	1.7

Source: Union Health Center: Boston, 1953. Unpublished data.

Table 4.—*Number and type of laboratory services, Union Health Center, Boston, 1952*

Type of service	Number	Number per 1,000 eligible persons	Type of service	Number	Number per 1,000 eligible persons
Total	[1] 10,410	[1] 694.0	Sedimentation rate	2,466	164.4
			Smears	1	0.1
Blood chemistry and sugars	394	26.3	Sputum	39	2.6
Differential count	2,469	164.6	Stool	42	2.8
Gastric analysis	3	0.2	Urine	2,562	170.8
Hemoglobin	2,481	165.4	White blood count	2,471	164.7
Hinton (taken only)	2,273	151.5	Miscellaneous	133	8.9
Red blood count	2,480	165.3			

[1] Each "complete blood count" (made 2,468 times) counted as 1 service in totals, and 4 services in subtotals. Subtotals therefore add to 17,814 services or 1,188 per 1,000 eligible persons.

Source: Union Health Center: Boston, 1953. Unpublished data.

istration), the assistant director who serves as director of public relations, and the medical director. The medical director's duties consist of supervision of the entire medical program and personnel, reviewing all records, dictating all records with positive findings that are to be sent to the family physician, processing of sick-benefit claims, attending all pertinent meetings and conferences.

Records and research

Results of all examinations are centralized in the patient's file. All diagnoses are coded according to the *Standard Nomenclature of Diseases*.

Other health and welfare benefits

Hospitalization—$4 a day for up to 30 days in each year.

Surgical—$50 maximum during the year plus $50 for maternity cases.

Tuberculosis—$250.

Retirement—$50 a month in addition to OASI benefits.

Sick benefits—$10–12 a week for a maximum of 10 to 13 weeks each year.

Life insurance—$1,000 after 2 years' membership.

SOURCE

Correspondence and unpublished data, Union Health Center, Boston.

American Federation of Labor*
Medical Service Plan of Philadelphia

Franklin and Thompson Streets
Philadelphia, Pennsylvania

This is a group medical practice plan established in 1951 through the sponsorship of the Central Labor Union of the American Federation of Labor, with the support of its affiliated locals. A medical center provides health and medical services to ambulatory patients, serving only members of participating locals and their dependents. On March 1, 1953, 18 locals had enrolled 17,958 persons, including both members and dependents. All costs are defrayed by funds provided through collective bargaining agreements or agreements with employer associations. Average cost per eligible person per year in 1952 was about $14.

The program represents the culmination of 6 years of planning by the Central Labor Union of the A. F. of L. in Philadelphia for a medical center which would provide its members with preventive service and medical care. The original stimulus came in 1946, when the Central Labor Union called a meeting of affiliated locals to discuss the project. Interest continued to grow, and the first step toward the establishment of a health center for organized labor was taken early in 1951, when the Luggage Workers, local 61, put up $20,000 for this purpose. Other locals agreed to participate, and under the sponsorship of the Central Labor Union, the program was developed.

Funds for modernizing and equipping the center were obtained through loans from builders, hospital equipment concerns and others, since the participating unions had accumulated no funds for this purpose. Current expenditures represent the combined resources of individual local unions whose collective bargaining agreements with their employers provide for medical center services from health and welfare funds.

The center opened in April 1951 to provide services to three unions having a total of 3,000 members. Participating unions were: Luggage

*Joseph A. McDonough, Chairman; R. Ralph Bresler, M. D., Medical Director; Isidor Melamed, Executive Director.

Workers Union, local 61; Painters' District Council, No. 21; and Meat Cutters, local 195; six additional unions joined during the first year of operation, making the center's membership at the end of the first year in excess of 9,000. During the second year both the number of participating unions and the membership at the center doubled.

In June 1953 the organization received a charter under the nonprofit corporation law of the State of Pennsylvania.

Basic objectives outlined by plan

It is the purpose of the American Federation of Labor Medical Service Plan of Philadelphia to provide adequate medical care for the members of organized labor and their immediate families. It is the purpose of the plan to effectuate this objective by understandings entered into between the various local unions affiliated with the American Federation of Labor. Such local unions must as a condition precedent contain a health and welfare clause in their collective bargaining agreement.

The American Federation of Labor Medical Service Plan of Philadelphia shall be divided into two parts:

1. Basic services, which shall provide all necessary medical and technical departments to take care of ambulatory cases. All affiliates must subscribe to this part of the medical service plan.
2. Extended services, which shall provide hospitalization, surgery, convalescence, etc. These services are not obligatory for affiliates, but they shall be instituted if and when a group of unions representing a minimum of at least 10,000 workers will decide to do so.

Eligibility

Eligibility is limited to members of participating unions and their dependents. Each union determines eligibility requirements for its affiliates so variations are found from one union to another. Each participating union is required to enroll for 3 years, the contract being renewable yearly thereafter.

Unions may qualify for participation in the plan if they fall into the following categories:

1. All A. F. of L. unions in Philadelphia area that represent, by contractual relations, the workers of a given industry.
2. All A. F. of L. unions in Philadelphia area that represent, by contractual relations, a craft or only part of the workers in a given industry.
3. All A. F. of L. unions in Philadelphia area that represent, by contractual relations, individual shops, factories, or mills, provided that all workers of a given bargaining unit are affiliated with the plan.
4. Unions having agreements with governmental agencies—Federal, State, or local—are excluded from above provisions, but may be accepted in the plan by special arrangements entered into between them and the general committee.

Membership

Average annual membership.—During the fiscal year April 1951 to March 1952, an average of 6,038 persons were eligible for benefits.

Only the staff of the Central Labor Union office, members of Luggage Workers, local 61, and their dependents, members of Painters' District 21, and some members of the Meat Cutters, local 195, were eligible for care during the entire fiscal year. In the second year (April 1, 1952, to March 31, 1953), average annual membership was 13,819.

Total membership.—During the first 23 months of the center's operation (April 1, 1951, to March 1, 1953), the membership increased from 3,000 persons to nearly 18,000. Dependents now represent more than one-third of the total membership, although they are covered by only 5 of the 18 participating locals.

Year	Number of Eligibles		
	Total	Members	Dependents
Apr. 1, 1951	3,000	NA	NA
Apr. 1, 1952	9,009	8,109	900
Mar. 1, 1953	17,958	11,278	6,680
Luggage Workers, local 61	620	200	420
Meat Cutters, local 195	2,700	2,700	----
Plumbers Union, local 690	3,964	1,416	2,548
Counter Workers, local 232	452	140	312
Teamsters Union, local 463	225	225	----
Building Service Union, local 69	2,200	1,300	900
Bakery and Confectionery Workers, local 492	85	85	----
Bakery and Confectionery Workers, local 429	1,216	1,216	----
Plasterers, local 8	362	362	----
Building Service, local 252	80	80	----
Sugar Refinery, local 1648	770	770	----
United Garment Workers, locals 140 and 75	312	312	----
Machinists, lodge 1	25	25	----
Firemen and Oilers, local 473	27	27	----
Window Cleaners, local 125	206	206	----
Bakery and Confectionery, local 6	214	214	----
Painters District Council, 21	4,500	2,000	2,500

Method of financing and cost of care

Method of financing.—The initial expenditures for modernizing and equipping the center (provided rent free for the first 8 months) amounted to about $126,000, including $10,000 for X-ray equipment. No funds had been accumulated by the unions for this purpose. Rather than postpone establishment of the center until the locals were able to build up funds, the necessary money was secured through loans which are now being repaid. Additional expenses for facilities and equipment have been financed from current income.

Total cost of facilities and equipment during the first 2 years of operation:

Total	$163,000
Remodeling	59,000
X-ray equipment	34,000
Other medical equipment	43,000
Furniture and fixtures	23,000
Other	4,000

Funds for operating costs are derived from a per capita amount, assessed for each member. The per capita amount is determined annually by the general committee and is the same for each of the participating locals. After further experience, a different system of payment may be set up, based either on a per capita cost or on the volume of services provided by the health center to members of each union.

Annual per capita payments during the first 2 years of operation, April 1, 1951, to March 31, 1953:

Single worker	$15.00
Couple or single worker and 1 dependent	30.00
Family, regardless of size	37.50

Dependents not covered by the plan may receive X-ray, laboratory, and other technical services at cost.

In most cases, the per capita assessment is paid from the locals' health and welfare funds secured by collective bargaining agreements. There are, however, a number of affiliated unions which do not have health and welfare funds but have agreements with the employer associations whereby the employers either make payments directly to the center or to labor-management trustees, who in turn forward payments to the center for these groups. In some instances, agreements are made between the unions and independent employers for payment to the plan through a labor-management trustee.

In order to assure stability of the plan, the general committee is authorized to provide for a reserve equal to the cost of 3 years of operation. In times of crisis, the executive board may waive part or all of unions' contribution.

Operating costs.—Because of the rapid expansion of membership (a 500 percent increase in 2 years), a change in the accounting period, and other related reasons, detailed data on operating costs are not available. Total operating costs for the year April 1, 1952, to March 31, 1953, were $197,000, broken down as follows:

Total	$197,000
Payments to physicians	52,000
Salaries, ancillary personnel	33,000
Administrative salaries [1]	16,000
Medical equipment, furniture, replacements and repairs	23,000
Medical supplies, building maintenance and rent	30,000
Debt payment	25,000
Other (printing stationery, telephone, taxes, etc)	18,000

[1] Excludes executive director who serves without pay.

During the fiscal year 1953, payments to medical and technical personnel accounted for about 43 percent of the total expenses of the medical center, and repayment of debts incurred for remodeling and equipping the center accounted for another 13 percent.

The center pays rent of $4,000 per year; during the first 8 months, space was provided rent free.

Average cost per member.—About $14.26 during the fiscal year 1953.

Payments to physicians.—The physician employed at the medical center on a full-time basis is paid an annual salary of $7,500. Part-time physicians are paid $13 for a 2-hour session. During the fiscal year April 1, 1951, to March 31, 1952, a total of $24,000 was paid to physicians, and during the following fiscal year, physicians received $52,000.

Services Provided

General medicine and specialist services, including a complete physical on the first visit to center and periodically thereafter upon request, are provided to ambulatory patients. The initial appointment for the patient is made through the union office, all subsequent appointments being made by the patient directly with the center.

General medical and specialist care.—The patient is assigned to an internist during his first visit to the center. This internist is responsible for performing a routine physical checkup and for requesting any specialist, diagnostic, or technical services he considers necessary. He acts as personal health advisor to the patient throughout all subsequent visits to the center and coordinates the findings of specialists and technicians. Specialties include: internal medicine, gynecology, eye, ear, nose, and throat, gastrointestinal, proctology, minor surgery, skin, psychiatry (added September 1951), peripheral vascular, pathology, diabetes, pediatrics, chiropody (added August 1952), cardiac, metabolic, endocrine, allergy, orthopedics, neurology, urology, and radiology.

Ancillary services.—Diagnostic X-ray, all standard laboratory procedures, electrocardiograms, basal metabolism, physiotherapy, audiometry, and oscillometry.

Cooperative services.—Center will perform preemployment examinations upon request of the union or the employer. Upon special occasions, for example during a flu epidemic, the center staff has gone into the shop to provide immunization services and special X-rays and examinations for exposed workers and dependents, regardless of whether the union had family coverage.

Upon written request of the family physician, the center provides technical services at cost to dependents not covered by the plan and forwards report to physicians.

Other services.—Drugs, eyeglasses, and various appliances are provided through outside facilities at reduced rates.

Services not provided.—Dental care and physicians' services in home or hospital as part of plan. Where patient has inhospital medical and surgical coverage through Blue Shield or insurance company

and elects to receive care from a physician on the center's staff, the physician accepts insurance indemnity as full payment for his services.

Facilities

The center occupies the first floor of St. Luke's and Children's Hospital Building. It covers about 10,000 square feet. Its quarters have been remodeled and equipped with modern facilities.

The center is open from 9 a. m. to 7 p. m. Mondays through Fridays and from 9 a. m. to 1 p. m. on Saturdays.

Staff

Administrative staff.—As of March 1, 1953, the medical center had 6 full-time persons, a part-time executive director, and 2 part-time clerks. The full-time staff included 3 secretaries (of these, 1 is a medical secretary and another compiles statistics), 1 appointment clerk, one telephone operator, and 1 clerk.

Medical and ancillary staff.—On March 1, 1953, the medical center had on the staff 29 part-time physicians and 1 full-time physician in addition to the medical director. The center does not have any general practitioners on the staff; the usual functions of general practitioners are performed by internists. The full-time physician and five of the part-time physicians were internists. The other physicians represent various other specialties.

The center employed a full-time nursing staff of 5, including a nursing director, 3 registered nurses, and 1 practical nurse. In addition, the center had on the staff 2 full-time laboratory technicians and 2 full-time X-ray technicians.

Qualifications for physicians.—Staff specialists are selected on the basis of their professional qualifications, experience, special training, and their standing in the community. Most of the staff is board qualified, and those younger men who have not passed their specialty board are either board eligible or working toward that status. Chiefs of departments are generally board qualified.

Physicians' hours.—Physicians in all the specialties provided 4,126 hours of service during the year ending March 31, 1952, or an average of 683 hours for each 1,000 eligible persons. Over 38 percent of all hours of service were provided by physicians in general medicine, and another 13 percent, by radiologists. Pediatric services accounted for the smallest percentage of physicians' time, reflecting the small number of dependents covered. Table 1 shows, for each specialty, the total number of physicians' hours and the number of hours per 1,000 eligible persons during the fiscal year.

Utilization of services

Persons receiving care.—During the year April 1, 1951, to March 31, 1952, 1,713 persons visited the center. The 1,713 patients represented 28.4 percent of the average monthly membership. Those union

members who were enrolled for a full year used the center somewhat more frequently. Table 2 shows, for each of the seven locals affiliated with the plan for 1 month or more during fiscal year 1952, the number of members enrolled, the number receiving care, and the total number of visits to each department. In the unions whose members belonged to the plan for a full year, about 1 eligible in 3 visited the center during the year.

Total services provided.—The 1,713 persons who used the center during the year made 16,338 visits, an average of 9.5 visits per patient and 2,706 visits per 1,000 eligible persons. Of the 16,338 visits, 10,600 were to physicians. Nearly 13,000 services were provided by the technical department, or about 2,100 per 1,000 eligible members.

Services provided by medical departments.—All physicians' visits totalled 1,754 per 1,000 eligible members. More visits were made to the departments of general (internal) medicine and injection therapy than to any other. There were more than 700 visits per 1,000 eligible members to the general medical department and 350 visits per 1,000 eligibles to the injection therapy department. The eye department gave an average of 1 service to each 10 eligible members. Table 3 gives the total number of visits to each department during the year and the number of visits per 1,000 eligible persons.

Services provided by technical departments.—During the year 1951–52 the following services were provided:

X-ray department:	
Number of services	2,537
Number of visits to department	1,991
Number of films used	4,508
Laboratory department:	
Number of services	7,907
Number of visits to department	1,693
Physiotherapy department:	
Number of services	1,668
Number of visits to department	1,536
Electrocardiogram	402
Audiometer	70
Basal metabolism	53

Each 1,000 eligible persons received 420 services in the X-ray department, 1,308 services in the laboratory department, and 276 services in the physiotherapy department.

Table 4 presents a detailed breakdown of type of service provided at the center in each of these three departments.

Administration

Title to all funds and other assets is vested in the plan as a trust, with no employee, employer, or union having any right, title, or interest thereto.

Table 1.—*Physicians' hours, by specialty, A. F. of L. Medical Center, Philadelphia, April 1951–March 1952*

Specialty	Number of hours		Specialty	Number of hours	
	Total	Average per 1,000 eligible persons [1]		Total	Average per 1,000 eligible persons [1]
All physicians	4,126	683.3	Urology	102	16.9
			Allergy	98	16.2
General medical	1,586	262.7	Proctology	90	14.9
Radiology	520	86.1	Minor surgery	62	10.3
Gastroenterology	275	45.5	Pathology	52	8.6
Orthopedics	265	43.9	Neurology	48	7.9
Eye	246	40.7	Diabetes	46	7.6
Ear, nose, and throat	193	32.0	Gynecology	40	6.6
Physiotherapy	188	31.1	Peripheral-vascular	19	3.1
Dermatology	136	22.5	Endocrinology	16	2.6
Cardiology	131	21.7	Pediatrics	13	2.2

[1] Based on the equivalent of 6,038 members eligible for entire 12-month period.

Source: A. F. of L. Medical Service Plan: *Philadelphia Labor-Medical Story*. Philadelphia, (May) 1952.

Table 2.—*Annual number of patient visits classified according to union affiliation, A. F. of L. Medical Center, Philadelphia, April 1, 1951–March 31, 1952*

Type of visit	All unions	Number of visits by union members						
		Luggage workers local 61	Painters district 21	Central Labor Union	Meat cutters local 195	Teamsters local 463	Plumbers local 690	Building service employees local 69
Number of members enrolled [1]	9,009	[2] 1,200	1,500	11	[3] 3,400	[4] 248	[5] 1,150	[6] 1,500
Number who received care	1,713	457	480	4	545	31	148	48
All visits	16,338	4,216	4,784	5,507	1,246	247	289	34
Medical departments:								
General medical	4,295	1,067	1,232	11	1,516	74	314	81
Gynecology	118	61	5		50			2
Eye	649	199	158	2	212	6	51	21
Ear, nose, and throat	595	148	153		225	4	59	6
Gastrointestinal	223	78	83		49	3	9	1
Skin	506	173	137		177	4	9	6
Endocrine	10	10						
Minor surgery	168	23	55		73	2	13	2
Orthopedics	589	164	237	2	143	7	30	6
Proctology	330	94	92		111	3	26	4
Injection therapy	2,120	649	596		715	1	150	9
Urology	322	93	106	2	100	11	8	2
Cardiac	177	59	56		45	4	11	2
Diabetic	59	13	16		30			
Pediatric	36	36						
Peripheral-vascular	66		44	1	21			
Neurology	44		30			6	6	2
Allergy	286	86	89		85	3	21	2
Technical departments:								
Audiometer	70	19	19		23		8	1
Basal metabolism	53	13	13		19	3	5	
Physio-therapy	1,536	428	475		446	31	139	17
Electrocardiogram	402	79	126	2	127	12	44	12
Laboratory	1,693	362	427	6	688	29	150	51
Radiology X-ray	1,991	362	615	8	672	79	193	62

[1] Average of 6,038 members covered during 12-month period.
[2] Only union providing family coverage during first year; above figures include 300 workers and their dependents.
[3] Only 298 members covered for 12 months, balance covered for 8 months; equivalent to 2,366 covered for 12 months.
[4] Only 8 months coverage; equivalent to 165 covered for 12 months.
[5] Only 7 months coverage; equivalent to 671 covered for 12 months.
[6] Only 1 month coverage; equivalent to 125 covered for 12 months.

Source: A. F. of L. Medical Service Plan: *Philadelphia Labor-Medical Story*. Philadelphia, (May) 1952

Table 3.—*Annual number of patient visits to A. F. of L. Medical Center, Philadelphia, Apr. 1, 1951–Mar. 31, 1952*

Type of visit	Number of visits		Type of visit	Number of visits	
	Total	Average per 1,000 eligible persons [1]		Total	Average per 1,000 eligible persons [1]
All visits	16,338	2705.9	Medical departments—Con.		
Medical departments:			Gynecology	118	19.5
General medicine	4,295	711.3	Peripheral-vascular	66	10.9
Injection therapy	2,120	351.1	Diabetes	59	9.8
Eye	649	107.5	Neurology	44	7.3
Ear, nose, and throat	595	98.5	Pediatrics	36	6.0
Orthopedic	589	97.5	Endocrinology	10	1.7
Dermatology	506	83.8	Technical departments:		
Proctology	330	54.7	X-ray	1,991	329.7
Urology	322	53.3	Laboratory	1,693	280.4
Allergy	286	47.4	Physiotherapy	1,536	254.4
Gastroenterology	223	36.9	Electrocardiograms	402	66.6
Cardiology	177	29.3	Audiometer	70	11.6
Minor surgery	168	27.8	Basal metabolism	53	8.8

[1] Based on the equivalent of 6,038 members eligible for entire 12-month period.

Source: A. F. of L. Medical Service Plan: *Philadelphia Labor-Medical Story.* Philadelphia, (May) 1952

Each affiliated local is required to have its own medical service plan committee responsible for financial matters and for acting as liaison between the general committee and the local. The general committee consists of two representatives from each local medical service plan committee and from the Central Labor Union, A. F. of L., of Philadelphia; it has full charge of all activities, projects, and undertakings of the center. The general committee meets every 3 months.

An executive board, elected by the general committee and composed of members of the committee, administers the program. The board is responsible for such activities as setting up subcommittees, authorizing expenditure of funds, including purchasing of facilities and equipment, and employing personnel. Authority of the board includes the right to accept or reject applications from unions, with the union having the right to appeal to the general committee in case of rejection.

The medical advisory board is composed of the medical director and two other physicians in the community. Dr. Joseph A. Langbord, medical director of the Sidney Hillman Health Center of Philadelphia, and Dr. Curtis Dohan, chief of the diabetic clinic of the University of Pennsylvania, now serve as members along with Dr. R. Ralph Bresler, the medical director.

Records

A complete medical record is maintained for each patient. Each physician examining or treating a patient makes a chronological record of services; all records of X-ray and laboratory services are maintained in the same file.

Table 4.—*Annual number of specified services provided at A. F. of L. Medical Service Center, Philadelphia, Apr. 1, 1951–Mar. 31, 1952*

Type of service	Number of services		Type of service	Number of services	
	Total	Average per 1,000 eligible persons [1]		Total	Average per 1,000 eligible persons [1]
X-ray department total	2,537	420.2	Bromsulphalein	15	2.5
			Calcium	4	.7
Barium enema	75	12.4	Cephalin flocculation	9	1.5
Cervical spine	40	6.6	Cervical	2	.3
Chest	685	113.4	Clot retraction	4	.7
Cholangiogram	1	.2	Clotting time	1	.2
Extremities	353	58.5	Coagulation time	6	1.0
Flat plates	12	2.0	Colloidal gold	14	2.3
Fluoroscopic examination	624	103.3	Culture	10	1.7
Gall bladder	85	14.1	Fishberg concentration test	2	.3
Hips	20	3.3	Fragility	2	.3
Intravenous program	43	7.1	Gastric analysis	31	5.1
Lumbar spine	154	25.5	Gastric contents	3	.5
Mastoid	7	1.2	Globulin	6	1.0
Maxilla	1	.2	Glucose tolerance	10	1.7
Pelvis	12	2.0	Hematocrit	5	.8
Ribs	9	1.5	Hemogram	1	.2
Sinuses	106	17.6	Heterophile antibody	4	.7
Skull	41	6.8	Icterus index	5	.8
Small bowel	4	.7	Nasal	7	1.2
Swallowing function	12	2.0	Phenolsulfonphthalein	1	.2
Teeth	2	.3	Platelet count	7	1.2
Thoracic spine	31	5.1	Prothrombin	4	.7
Upper G. I. tract	219	36.3	Quantitative Wassermann	29	4.8
Uterosalpinography	1	.2	Reticulocyte count	3	.5
			Semen examination	2	.3
Laboratory department total	7,907	1309.5	Sickling test	1	.2
			Smears	8	1.3
Acid phosphate	6	1.0	Spinal fluid	14	2.3
Addis count	2	.3	Sputum	42	7.0
Albumin	6	1.0	Stippling	2	.3
Basal metabolism	58	9.6	Stool	89	14.7
Bence Jones protein	3	.5	Total protein	34	5.6
Biliary drainage	2	.3	Urine analysis	1,268	210.0
Bleeding time	6	1.0	Van den Bergh	7	1.2
Blood acid	1	.2			
Blood alkaline phosphatase	10	1.7	Physiotherapy department total	1,668	276.3
Blood cholesterol	56	9.3			
Blood cholesterol esters	21	3.5	Diathermy	715	118.4
Blood count	3,729	617.6	Galvanism	34	5.6
Blood sedimentation	441	73.0	Infrared	281	46.5
Blood sugar	592	98.0	Massage	115	19.0
Blood thiocyanate	7	1.0	Medcatron stimulation	261	43.2
Blood urea nitrogen	223	36.9	Sinusoidal current	169	28.0
Blood uric acid	42	7.0	Traction	45	7.5
Blood Wassermann	1,048	173.6	Ultraviolet	21	3.5
Bone marrow examination	2	.3	Whirlpool	27	4.5

[1] Based on the equivalent of 6,038 members eligible for entire 12-month period.

Source: A. F. of L. Medical Service Plan: *Philadelphia Labor-Medical Story.* Philadelphia (May) 1952.

Other health and welfare benefits

Members of participating locals are eligible for the following benefits through health and welfare programs under collective bargaining; the type and volume of coverage varies with each participating local.

Sick leave.—Varies from $16 to $30 a week up to 26 weeks for sickness and for accidents occuring outside the shop.

Hospitalization.—Benefits vary from $7 to $9 a day up to 31 days for sickness and up to 62 days for accidents occuring outside of shop.

Surgery.—Up to $350.

Maternity benefits.—$75.

Life insurance.—Policies vary from $250 to $3,000.

Retirement pensions.—Only one group in local 463 of the Teamsters Union has retirement benefits.

VARIOUS EVALUATIONS

At the end of the first year, the officers of the Medical Service Plan reviewed its accomplishments. The counsel for the plan commented particularly on the fact that a group of workers in different industries and crafts, with a heterogeneous set of employers, was able to achieve, through collective bargaining, medical services for the workers. The executive committee of the Central Labor Union, speaking on behalf of its members, emphasized the important contribution made by the employers to the health and well-being of the workers. The full text of both these comments appears in exhibit A.

Exhibit A.—*Evaluations, American Federation of Labor, medical service plan of Philadelphia.*

Statement by M. Herbert Syme, counsel for the Medical Service Plan:

The American Federation of Labor undertaking was much more complicated than the ladies' garment venture (International Ladies' Garment Workers' Union health center, in Philadelphia). The garment workers were a homogeneous group. They had one contract with one group of employers. The contributions came into one treasury. The A. F. of L. venture, on the other hand, comprised a group of industries, workers of different crafts dealing with a heterogeneous set of employers. How to develop a formula for this divergent group that would operate with ease and effectiveness was a challenge to the resourcefulness of the A. F. of L. leadership.

A year passed. What seemed impossible has been achieved. The center is here. The staff is here. Clinical services are rendered to workers. An agreement has been worked out—an agreement with the employers—an agreement with the affiliated locals and the A. F. of L. health center.

This is no substitute for health insurance or for a vast Government project. It does not pretend to be. It is a cooperative effort, however, between labor and industry to provide needed medical services for workers. It is important because it is done in the best traditions of collective bargaining. It is important because it recognizes the responsibility of American industry toward the worker. It is important because it recognizes the labor union not merely as a vehicle for securing better wages, shorter hours, improved working conditions, but as a medium that permeates the life and welfare of the worker. It is one more acknowledgment of the fact that the trade union is becoming increasingly a way of life.

Statement by the executive committee of the Central Labor Union of Philadelphia and vicinity on behalf of its members:

In preserving and maintaining the health of our workers, the interests of both labor and industry run parallel.

To a labor union, a membership healthy in mind and body represents a membership alert to its own interests and responsive to the obligation it assumes to industry.

To industry as a whole and to the individual employer, the health of the worker is one of the biggest assets to their business.

The above principle was clearly recognized by the employers both in association and as indivduals when they accepted the idea of covering their employees with medical services rendered at this center.

For this action on the part of our employers, our affiliated unions express their everlasting thanks on behalf of the workers in their respective industries.

As time passes, the history of our work will record this action on the part of our employers' groups as one of the most important contributions ever made by them to the well being and happiness of the people who earn a living in their industries and whose only asset is their health.

Source: American Federation of Labor Medical Service Plan: *Philadelphia Labor-Medical Story,* Philadelphia, (May) 1952, 28 pp.

SOURCES

A. F. of L. Medical Service Plan: *Philadelphia Labor-Medical Story.* Philadelphia, The Plan, 1952.

A. F. of L. Medical Service Plan: *Presenting the American Federation of Labor Medical Center.* Philadelphia, The Plan, 1951.

Correspondence and personal interviews.

The Sidney Hillman Medical Center* of the Male Apparel Industry

2116 Chestnut Street

Philadelphia, Pennsylvania

A group practice health center established in 1951 to provide complete medical care to ambulatory patients, it now serves approximately 23,000 members of the male apparel industry in Philadelphia. The center is a joint labor-management project. Both groups actively participated in planning and made equal contributions toward financing facilities. Title to land and building is jointly held. Total operation costs amounting to about $350,000 annually are paid by employers under collective bargaining contracts. Average cost per eligible person for fiscal year 1951–52 was $14.77.

Planning for the project began in 1946 when union members proposed to representatives of the Philadelphia Clothing Manufacturers' Association that funds be set aside by the employers for maintaining and operating a center which would be built and equipped by $20 contributions from union members; under a later arrangement, employers and union agreed to contribute equal sums to the initial cost of the center.

Most of the shops in the industry are small, and with few exceptions, do not provide inplant health services. However, the favorable experience of the firms that were making such services available to their employees stimulated general employer interest in establishing a joint center as a means of reducing absenteeism among workers. As a practical approach to the problem, a long-range program providing ambulatory medical care was proposed, with employers actively participating in the planning.

The need for and value of health services was substantiated by the findings of a preliminary program inaugurated in 1948. Members received special tests and examinations, without cost, upon the written request of their private physicians, to whom resulting information was sent. The 1,870 referrals handled between September 1948 and April 1951 cost $44,353, and were paid out of funds appropriated for

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*Charles Weinstein, Manager, Philadelphia Joint Board Amalgamated Clothing Workers of America, and President, Medical Center; Joseph B. Seitchik, President, Philadelphia Clothing Manufacturers' Association, and Vice President, Medical Center; Joseph A. Langbord, M. D., Medical Director, Albert Wells, Business Administrator and Treasurer.

the center. The program showed that some members of the union lacked funds to obtain specialist services recommended by their private physicians; it also uncovered a number of unsuspected illnesses in time to save lives, and demonstrated the importance of having general practitioners and specialists work closely with each other.

When the center was established in 1951, it was named at the suggestion of employer-members of the center's board of trustees, in honor of the founder and first president of the Amalgamated Clothing Workers of America.

Basic objectives outlined by plan

On the basis of the findings of the emergency program, and joint study and planning by union and employer representatives, the following were drafted by the board of trustees:

1. Specialist service for ambulatory and chronically ill.
2. Consultation service to patients who voluntarily come to center and to patients referred to center by their attending physician.
3. Intensive laboratory services for voluntary patients and for referred patients on request of physician.
4. Preventive medical services, including periodic physical examination and health education.
5. Cooperation with private physicians referring patients to center.

Eligibility

To be eligible, a person must hold membership in one of the 16 locals of the Philadelphia joint board of the Amalgamated Clothing Workers of America. A stamp received at time of payment of monthly union dues is proof of eligibility. Member is eligible for care for three months after the last month for which dues were paid.

Membership

About 23,000 members of the 16 locals of the Philadelphia joint board of the Amalgamated Clothing Workers of America are covered. Membership in locals varies from 200 to 5,000 persons, with 8 locals having less than 1,000 members.

Average annual salary of members in 1951 was about $2,000.

Members range from 18 to 70 years of age, with about equal representation of males and females.

Dependents were not covered until March 1, 1953, when dependent wives and husbands of members in the clothing industry proper became eligible. Negotiations are now under way to cover dependent wives and husbands of members in the cotton garment industry.

Method of financing and cost of care

Method of financing.—Construction and equipment of the center were financed by equal contributions from union members and employers; the total expenditure of $1,280,540 is broken down as follows:

Building and land	$1,086,797
Medical equipment	41,344
Dental equipment	3,170
Optical equipment	5,490
X-ray equipment and accessories	87,346
Library	2,540
Office equipment, furniture and fixtures	53,850

Operation of the program is financed by employer contributions. Prior to January 1, 1953, such contributions were equivalent to 0.75 percent of the payroll in the clothing industry proper and 1 percent in the cotton garment industry (because of its different makeup). Contributions for employees in the clothing industry proper now constitute 1.25 percent of payroll—0.75 percent for employees and 0.50 percent for their dependent husband and wives.

Operating costs.—First-year operating costs were $336,000; costs for the second year are estimated at $360,000. The annual cost includes an item of $41,000 for depreciation of building and equipment.

Payments to medical and related staff accounted for nearly half of all costs. Total operating expenses, by broad category, are shown in table 1.

Average cost per member.—Fiscal year 1951–52—$14.77.

Cost per visit.—Average cost to the clinic for each visit varied from $4.46 in the department of urology to $9.11 in the department of surgery. X-ray procedures cost on the average, $5.95 per service, and X-ray therapy, $13.62. Table 2 gives the average cost, both direct and indirect, of each patient visit by department and by type of service.

Payment to physicians.—The original plan for remuneration of physicians was based on $14 for a 2-hour session, or an annual payment of $2,000 for 150 sessions. As of January 1, 1953, the arrangement was changed so that physicians receive $7 per hour during the first year, $8.50 per hour during the second year, and $10 per hour thereafter. Payments to staff physicians were $105,000 during the fiscal year 1952, not including about $2,000 for outside consultations.

Services provided

Comprehensive medical care is provided to ambulatory patients at the center. Appointments are required for all visits. Referred patients receive services requested by family physicians.

General medical and surgical care.—Each "voluntary" patient (those not referred by a personal physician) is assigned to an internist who remains "the doctor" throughout treatment. He gives the initial examination, including a gynecological examination for women, orders any special examinations necessary and correlates the results of the examinations. He may call on any specialist for assistance in diagnosis and for treatment. (See table 3 for listing of specialists on center staff.) The surgery department handles minor

surgery and treatment of emergency cases; limited to cases not requiring overnight stay .

Ancillary services.—Routine examinations include extensive laboratory tests, chest X-ray, and other X-rays as needed. Laboratory is equipped to perform chemical, bacteriological, hemotological, serologic, and tissue tests. The radiology department gives superficial and deep therapy as well as diagnostic examinations. The physical medicine department treats all problems connected with malfunctioning of muscles and joints.

Cooperative services.—Patients under the care of a private physician receive only those examinations requested by him, and a report is sent to him after the procedures have been carried out.

The public health department functions as a coordinating unit and as the liaison between physician, patient, and community resources. See exhibit A for further details.

Other medical services.—Pharmacy fills prescriptions of staff physicians at cost.

Services not provided.—Medical and surgical care are not provided in home and hospital. Patients are entitled to cash hospitalization payments and inhospital surgery through health and welfare funds.

Facilities

The center is centrally located and accessible to most members. The building, newly constructed, is the result of careful planning for both present and future. The present building can accommodate a 50-percent increase in membership and can be expanded by the addition of other services. Facilities include extensive laboratory and treatment facilities, a pharmacy, a small auditorium, and an individual suite for each physician, including office examination alcove, two dressing rooms and vestibule; an unusual feature is semiprivate waiting rooms outside each physician's office instead of a common waiting room. Since industrial processes in the clothing industry often result in long hours of muscular tension, the center has a machine capable of exercising any group of muscles or joints in the body, the first of its kind installed in the East. The deep therapy X-ray machine is one of the few in existence and is the most expensive installation in the center.

The center is open from 9 a. m. to 6 p. m. daily and from 9 a. m. to 1 p. m. on Saturdays so that patients may attend clinics outside of working hours; laboratory and X-ray services are available all hours; the majority of the clinics are held in the late afternoon or on Saturdays.

Staff

Administrative staff.—At the beginning of 1953 the staff consisted of 21 persons, including 5 part-time clerks.

Professional staff.—On January 1, 1953, the staff included 48 part-time physicians, 5 full-time nurses, and 9 full-time and 2 part-time auxiliary staff members. The number of staff members associated with each specialty, and the average number of hours of service provided per week and per 1,000 persons eligible for service are shown in table 3.

Qualifications for physicians.—Staff is recruited through announcements in medical journals inviting physicians in various specialties to apply for employment at the center. Selections are made by an advisory committee of outstanding physicians. Applications are processed through the center's medical staff, and final approval is given by the board of trustees upon the recommendation of the medical advisory committee.

Utilization of services

Persons receiving care.—During the fiscal year May 7, 1951, to April 30, 1952, the center was visited by almost 6,000 patients, 26 percent of the average membership. About one-third, 1,998, were referred by private physicians, and 3,970 were self-referred. Patient visits totalled 45,944, an average of 7.7 visits per patient.

Total services provided.—The center provided 70,163 services during the year. Each patient received, on the average, 11.8 services including pharmacy visits for prescriptions; excluding such visits, the average was 10.5 services.

Services provided during first fiscal year were as follows:

Item	Number	
	Total	Per 1,000 eligible persons
Total services	70,163	3089.2
Clinical visits	28,111	1237.7
Diagnostic procedures	17,295	761.5
Ancillary therapeutic services	12,884	567.3
Other services:		
Public health	4,415	194.4
Pharmacy	7,458	328.4

Services provided by medical department.—Of the 28,000 visits to the medical clinic, 39 percent were to the department of general medicine and another 13 percent to the eye department.

Table 4 gives a breakdown of clinical visits by type and shows by broad categories the diagnostic and ancillary therapeutic services provided.

Services provided by ancillary departments.—During the year each 1,000 eligible persons received 495 X-ray examinations and 34 X-ray treatments. A total of 6,399 persons visited the X-ray department and received an average of 1.9 services each. On the average, 1.5

diagnostic X-rays were made of each part examined. Chest X-rays accounted for one-fifth of all parts examined. Table 5 presents a detailed breakdown of the services rendered by part examined; summary data on the X-ray department follow.

X-ray department:	
X-ray examinations:	
Number of parts examined	7,592
Number of services	11,231
Number of visits to department	5,651
X-ray therapy:	
Number of services	748
Deep	628
Superficial	120
Number of visits to department	748

Patients visiting the laboratory department received more than seven services each. On the average, each 1,000 eligible members received 2,021 laboratory tests. Six laboratory tests accounted for 65 percent of all laboratory services. About 46,000 laboratory services were performed in the course of 6,000 visits to the department. Table 6 shows the number of each type of laboratory test given and the number per 1,000 eligibles.

The physiotherapy department gave 22,849 services during 7,046 visits, or 3.2 per patient visit. Each 1,000 eligible persons received 1,006 physiotherapy treatments. Radiant heat and massage were the most frequent procedures. Table 7 presents a detailed breakdown of the physical medicine and rehabilitation treatments given.

Administration

Administration of both the center and the health fund is vested in the board of trustees consisting of 24 members, management and labor having equal representation. The board is empowered to make all necessary and appropriate regulations and to operate the center. Union members are designated by the Philadelphia joint board, Amalgamated Clothing Workers of America; management representatives are selected by the president of the Philadelphia Clothing Manufacturers Association; the chairmanship alternates annually between a management and a union representative.

The medical staff at the center has responsibility for all medical phases of the program; the medical director, Dr. Joseph A. Langbord, has been with the center since the planning stage and works closely with the board of trustees.

In 1953, the center established a corps of advisors composed of union members in various shops. Analogous to shop stewards but concerned primarily with health problems and acting as liaison between members and the center, these persons are given a training course to prepare them for this job.

Research

The union believes that the permanency of the center and the continuity of its relationship with its patients offers an excellent opportunity for research. Medical records are carefully supervised, diagnostic data recorded in accordance with standard nomenclature, and all records reviewed to determine their accuracy.

In 1951, a grant of $25,000 was received from the Sidney Hillman Research Fund of New York. Current research projects financed by this grant are a study of hepatosplenography and studies of the incidence of virus disease and of the incidence of musculoskeletal disorders.

With additional grants of $50,000 from the Sidney Hillman Foundation, matched by industry and union contributions, the center has established a research fund of $100,000. Plans for large-scale research programs are now being formulated.

Other health and welfare benefits

Services at the center are supplemented by the union's social insurance program. Benefits include:

Hospitalization—Nine dollars a day up to 31 days for sickness and up to 62 days for accidents occurring outside of shop.

Sick leave.—Twenty dollars a week up to 13 weeks for sickness and up to 26 weeks for accidents occurring outside of shop.

Surgery.—Up to $200.

Maternity benefits.—One hundred dollars.

Life insurance.—Five hundred dollar policy.

Retirement pension at 65.—Fifty dollars a month from pension program in addition to benefits under old age and survivors insurance.

Actuaries have estimated that the cost of privately purchased insurance providing all of the above coverage for a man aged 50 (the average age of men in the clothing industry) would amount to $560 a year.

Various evaluations

President Jacob S. Potofsky, general president of the Amalgamated Clothing Workers of America, considers the center "a living testimonial to sound and constructive industrial relations."

The Philadelphia joint board, Amalgamated Clothing Workers of America, states: "No one who now sees the medical center, its physical plant and its personnel, can imagine anything less than wholehearted, unstinting work by both employer and union officials went into its making. As an institution born of the intelligent teamwork of labor and management, the Sidney Hillman Center will serve as a monument to progressive industrial relations for coming generations."

Satisfaction of the patients is reflected in the center's report that not a single complaint was received during the first year of operation.

Acceptance by the medical profession is indicated by the fact that private physicians referred 2,000 patients to the center during first year of operation.

Dr. Louis B. Laplace, president of the Philadelphia County Medical Society, writing in 1951, commented on the high quality of the center's facilities and on its significance in serving low-income groups. He pointed out that ". . . what the Hillman Center has done for its union workers will have to be done, appropriately modified to the circumstances of individual groups, for millions of others." See exhibit B for more complete statement.

Exhibit A.—*Program of the Public Health Department, Sidney Hillman Medical Center, Philadelphia*

The public health department has as its general objective the maintenance of a maximum state of health for the worker through a combination of service and health education; it functions as a liaison between the patient, the physician and outside community resources. Patients are referred to this department by the examining physician and are seen in an individual interview. The first are scheduled by appointment to coincide, if possible, with other clinic visits to avoid loss of work time.

The organization states that a positive health program offered to the patient when he feels the need for medical service is of more value than the general or mass education methods. For this reason, the indirect health education approach is used to a great extent at the time of the patient's interview and is related to a specific service requested. The major areas of referral are described by the organization as follows:

1. Patients are referred for interpretation and clarification of physician's orders, special examinations, arrangements involving community resources, and clarification of policy. These visits may be of the single type or may involve several visits to the department.

2. Patients are referred for followup in certain special categories, the followup being the most extensive aspect of the public-health program. The center states that it is only by a direct and positive approach and program that the maximum state of health may be reached and maintained, and health education practiced rather than preached.

The major categories in the followup program are listed and described as follows:

1. All nutrition problems (obesity, special diets, diabetic diets, etc.) are referred for diet interpretation and health consultation. Followup appointments are scheduled when necessary. All diabetics are referred for diet instruction, insulin instruction, and diabetic health supervision. They are scheduled for supervision between visits to the doctor to insure continuity of care.

2. All photofluorograms that show abnormal findings are referred to this department and patients notified to return for a 14 by 17 film chest X-ray. If positive, they are followed through the medical evaluation and further disposition is made. All contacts of patients with diagnosed tuberculosis are interviewed and chest X-rays arranged for. Patients are listed for routine followup by this department and are notified of the specified time to come in for repeat chest X-rays and physical examination.

3. All positive serologies are referred to the department. Appointments for evaluation by the dermatologist are made and each patient is listed for routine

followup after being seen by the physician for arrangement of treatment, contact followup, and routine interval check.

4. All patients for whom electroconvulsive therapy is recommended are referred by the neuropsychiatrist for arrangement for medical clearance. Each patient is interviewed individually for interpretation of treatment. A member of the family is also interviewed for interpretation and signature of permit. All patients report directly to this office for instruction prior to treatment. They are interviewed to check any untoward symptoms (if present, referred to neuropsychiatrist before treatment). Followup on post electroconvulsive therapy is made at monthly intervals.

5. All patients suspected of possible precancerous lesions are seen and recommendations interpreted. Special followup is made, and patients are kept on an active list until a definitive diagnosis is established.

6. All patients for whom surgery is recommended are referred for interpretation. Appointments are made by the public health department for medical consultant evaluation, and the patient is seen immediately after medical consultation regarding surgeon, hospitalization, and arrangements as indicated by the individual problem.

7. A patient considered to require job adjustment for medical reasons is referred to the medical director or the assistant medical director for evaluation. If the patient is found to have a medical problem requiring alteration in his type of work, the matter is referred to the public health department. The public health counselor brings it to the attention of the union's business agent who reaches agreement with employer.

8. All social problems are seen for direct help or referrals to the proper community resource.

A statistical survey of the major classifications for active case followup, May 1951 to May 1952, will indicate in a small way the scope of the program which the organization feels is one of the most important and unique functions of a public health department in a diagnostic institution.

Questionable malignancy	50	Special followup	268
Diagnosed malignancy	20	Nutrition instructions	1,454
Apparently inactive tuberculosis	45	Job adjustment	29
Active tuberculosis	10	Hospitalization and convalescent care	104
Positive serology	69		
Lues—diagnosed	36	Total active case load, May 1952	5,071
Diabetes mellitus	54		
Electroconvulsive therapy	45	New	3,052
Carbon-dioxide therapy	85	Old	2,019
Solitary nodules of the lung	8		

Exhibit B.—*Evaluation by Louis B. Laplace, M. D., president, Philadelphia County Medical Society, of the Sidney Hillman Medical Center, Philadelphia*

A visit to the Hillman Medical Center is an impressive experience. The building is spectacular with its ultramodern design based on the latest concepts of hospital construction. The equipment is more elaborate and complete than I have seen in any institution of comparable size. The most important feature to us, however, is its function. . . .

Here is a very challenging situation. Patients of a low-income group receive medical care costing far more than they could possibly afford on the usual fee-for-service basis. Compare this with the types of medical care which are available to them otherwise: attendance at a hospital clinic, obtaining the favor of reduced fees by consultants, or entirely foregoing consultant and laboratory

studies which might be vitally necessary. The advantages to the patient therefore are obvious. Even the possibility that the patient may not appreciate the service because it is free is unlikely because of the impressive surroundings and his feeling that it is his own organization.

From the doctor's standpoint, there likewise appears to be no valid criticism. The staff physicians are, of course, employees of the union, but their status differs in no essential respect from that of physicians employed in industry, insurance and even in some hospitals. Little if any income is diverted from private physicians since this patient group can scarcely afford laboratory and consultant services.

The most significant feature to us of this situation is the fact that if all the advances of medical science are thus made available at no cost to members of a union, what will be the effect on all the other people in the low and middle income groups who also want medical care of comparable quality as part of their employment benefits, or at least without the unpredictable and often financially disastrous features of fee-for-service payment, especially fee at the time of service payment? The eventual effect can scarcely be doubted. The demand for more complete medical care on an insurance plan, paid by the employer, by some organization, or by the patient himself will increase until, in one way or another, it has been met. There will always be some who will pay on the conventional fee-for-service basis, but increasing taxation is inevitably reducing the number of those who can or prefer to do so.

This is our great opportunity to direct the further development of medical care programs into forms which will combine the best service to patients and the most satisfactory conditions for the doctor. What the Hillman Medical Center has done for its union workers will have to be done, appropriately modified to the circumstances of individual groups, for millions of others. Let us see that it is done right. . . .

Source: The President's Page, *Philadelphia Medicine,* (April 7) 1951.

Table 1.—*Operating expenses, Sidney Hillman Medical Center, Philadelphia, fiscal year May 7, 1951–Apr. 30, 1952, and budget for fiscal year 1953*

Item	Expenses 1952		Budget 1953	
	Amount	Percent	Amount	Percent
Total expenses	$335,503	100.0	$360,231	100.0
Administrative	62,787	18.7	69,965	19.4
Building maintenance [1]	77,001	23.0	80,190	22.3
Supplies and sundries [2]	32,103	9.6	30,200	8.4
Medical staff [3]	104,612	31.1	118,324	32.9
Auxiliary medical staff	56,626	16.9	61,052	16.9
Physical medicine	15,883	----	14,650	----
Nurses	9,679	----	11,752	----
Radiological department	7,569	----	8,320	----
Medical records librarian	3,116	----	3,640	----
Clinical laboratory	10,651	----	11,960	----
Public health	3,113	----	3,600	----
Medical statistician	1,500	----	1,500	----
Psychology	1,750	----	2,600	----
Assistant to psychiatrist	250	----	1,040	----
Other	3,115	----	1,990	----
Outside consultations	2,374	.7	500	.1

[1] Includes $41,000 depreciation of building and equipment for each year.
[2] Major items included in 1951 expenses: X-ray supplies, $15,086; medical supplies, $8,777; clinical laboratory supplies, $4,473.
[3] Includes salaries of medical director and assistant medical director. General medicine staff accounts for slightly less than one-third of medical staff expenditures for each year.

Source: Sidney Hillman Medical Center, Philadelphia, 1953. Unpublished data.

Table 2.—*Average cost of specified patient visit or service rendered, Sidney Hillman Medical Center, Philadelphia, fiscal year May 7, 1951–Apr. 30, 1952* [1]

Item	Number	Average cost		
		Total	Direct	Indirect
Clinical visits:				
Allergy	2,164	$5.10	$2.28	$2.82
Dental	688	6.48	3.65	2.83
Dermatology	822	5.11	2.28	2.83
Ear, nose, and throat	1,944	5.28	2.45	2.83
Endocrinology	197	5.99	3.17	2.82
Gastroenterology	202	7.03	4.19	2.84
Gynecology	[2] 2,198	5.37	2.54	2.83
Internal medicine	11,254	5.72	2.89	2.83
Ophthalmology	3,682	5.15	2.32	2.83
Orthopedic	1,461	4.66	1.84	2.82
Proctology	775	5.58	2.76	2.82
Surgery	611	9.11	2.39	6.72
Urology	425	4.46	1.64	2.82
Clinical visits and services:				
Cardiology	[3] 1,979	3.73	.90	2.83
Neuropsychiatry	[4] 3,507	4.59	1.76	2.83
Physical medicine	[5] 7,876	5.24	2.42	2.82
Diagnostic procedures:				
Clinical laboratory	6,131	4.37	2.02	2.35
Photofluorograms	3,043	3.09	.89	2.20
X-ray	5,651	5.95	2.83	3.12
Other services:				
Injection therapy	2,274	3.68	.85	2.83
Pharmacy	7,458	2.48	.35	2.13
Public health	4,415	3.55	.72	2.83
X-ray therapy	748	13.62	7.46	6.16

[1] More than 1 laboratory test made during same visit counted as 1 service; similar procedure for X-ray examinations and other services.
[2] Includes cancer detection and gynecology.
[3] Includes 167 clinical visits.
[4] Includes 691 clinical visits.
[5] Includes 830 clinical visits.

Source: Sidney Hillman Medical Center, Philadelphia, 1953. Unpublished data.

Table 3.—*Physicians, auxiliary medical and administrative staff, Sidney Hillman Medical Center, Philadelphia, Jan. 1, 1953*

Item	Staff personnel		Annual equivalent hours of service	
	Number	Average weekly hours of service per person	Total	Per 1,000 eligible persons [1]
Physicians by specialty	48	----------	[2] 14,820	652.5
Allergy	2	6	624	27.5
Cardiology	1	4	208	9.2
Dentistry	1	4	208	9.2
Dermatology	2	4	416	18.3
Ear, nose, and throat	2	7	728	32.1
Endocrinology	1	2	104	4.6
Eye	4	6	1,248	54.9
Gastroenterology	1	4	208	9.2
Gynecology	4	5	1,040	45.8
Hematology	1	2	104	4.6
Internal medicine	15	7	5,460	240.4
Neuropsychiatry	1	14	728	32.1
Orthopedics	2	5	520	22.9
Pathology	1	5	260	11.4
Peripheral vascular	1	2	104	4.6
Physical medicine	2	5	520	22.9
Proctology	1	7	364	16.0
Radiology	3	10	1,560	68.7
Surgery	2	2	208	9.2
Urology	1	4	208	9.2
Auxiliary medical staff	16	----------	[3] 30,680	1,350.8
Nurses	5	40	10,400	457.9
Laboratory technicians	3	40	6,240	274.7
Do	1	10	520	22.9
X-ray technicians	3	40	6,240	274.7
Pharmacist	1	40	2,080	91.6
Physiotherapist	1	40	2,080	91.6
Physiotherapy aide	1	40	2,080	91.6
Corrective therapist	1	20	1,040	45.8
Administrative staff	21	----------	[4] 38,480	1,694.3
Supervisor	1	40	2,080	91.6
Public health councilor	1	40	2,080	91.6
Medical records librarian	1	40	2,080	91.6
Telephone operator	1	40	2,080	91.6
Medical secretaries	3	40	6,240	274.7
Appointment clerks	4	40	8,320	366.3
Statistical clerks	1	40	2,080	91.6
Record clerks	4	40	8,320	366.3
	5	20	5,200	229.0

[1] Based on average 12-month membership of 22,712.
[2] Equivalent to 7.125 full-time physicians.
[3] Equivalent to 14.75 full-time persons.
[4] Equivalent to 18.50 full-time persons.

Source: Sidney Hillman Medical Center, Philadelphia, 1953; Unpublished data.

Table 4.—*Classification of services, according to type, Sidney Hillman Health Center, Philadelphia, fiscal year May 7, 1951–Apr. 30, 1952*

Item	Number		Item	Number	
	Total	Average per 1,000 eligibles [1]		Total	Average per 1,000 elibibles [1]
Clinical visits	28,111	1,237.7	Diagnostic procedures	17,295	761.5
Allergy	2,164	95.3	Basal metabolism	431	19.0
Cardiology	167	7.4	Electrocardiogram	1,812	79.8
Dental	688	30.3	Laboratory	6,131	269.9
Dermatology	822	36.2	Photofluoro	3,043	134.0
Ear, nose, and throat	1,944	85.6	X-ray	5,651	248.8
Endocrinology	197	8.7	Miscellaneous	227	10.0
Eye	3,682	162.1			
Gastroenterology	202	8.9	Ancillary therapeutic services	12,884	567.3
Gynecology [2]	2,198	96.8			
Medical	11,012	484.9	Carbon dioxide treatments [5]	1,531	67.4
Neuropsychiatric	691	30.4	Electroconvulsive therapy	97	4.3
Orthopedic	1,461	64.3	Group psychotherapy [6]	1,188	52.3
Proctology	775	34.1	Injection therapy	2,274	100.1
Surgery	611	26.9	Physical medicine	7,046	310.2
Urology	425	18.7	X-ray therapy—superficial	120	5.3
Medical consultations [3]	242	10.7	deep	628	27.7
Physical medicine consultations [4]	830	36.5	Other services:		
			Pharmacy visits	7,458	328.4
			Public health	4,415	194.4

[1] Based on average 12-month membership of 22,712.
[2] Includes cancer detection and gynecology.
[3] Separate count made starting February 1952.
[4] Separate count made starting November 1951.
[5] Services initiated January 1952.
[6] Services initiated August 1951.

Source: Monthly Statement of Statistics, Sidney Hillman Medical Center of the Male Apparel Industry of Philadelphia, 1952, mimeographed.

Table 5.—*X-ray examinations and therapy. Sidney Hillman Health Center, Philadelphia, fiscal year May 7, 1951–Apr. 30, 1952* [1]

Item	Number		Item	Number	
	Total	Average per 1,000 eligibles [1]		Total	Average per 1,000 eligibles [1]
X-ray examinations [2]	7,592	334.3	Leg	74	3.3
			Lumbar spine	645	28.4
Abdomen	76	3.3	Mandible	19	.8
Ankle	85	3.7	Mastoids	36	1.6
Barium enema	463	20.4	Nasal bones	7	.3
Breasts	5	.2	Pelvimetry	1	(3)
Cervical spine	255	11.2	Pelvis	50	2.2
Chest	1,620	71.3	Ribs	50	2.2
Cholecystogram	558	24.6	Sacroiliacs	47	2.1
Coccyx	28	1.2	Shoulder	395	17.4
Elbow	64	2.8	Sinuses	357	15.7
Facial bones	2	.1	Skull	235	10.3
Femur	43	1.9	Small bowel study	38	1.7
Fingers	8	.4	Thoracic spine	189	8.3
Foot	171	7.5	Toe	3	.3
Forearm	15	.7	Wrist	87	3.8
Gastroduodenal	981	43.2	Miscellaneous	99	4.4
Hand	194	8.5			
Heel	12	.5	X-ray therapy	748	32.9
Hips	56	2.5			
Humerus	12	.5	Deep	628	27.7
Intravenous urogram	342	15.1	Superficial	120	5.3
Knee	270	11.9			

[1] Based on average 12-month membership of 22,712.
[2] Represents count of each part X-rayed regardless of parts X-rayed at any one clinic visit.
[3] Less than 0.05 per 1,000.

Source: Monthly Statement of Statistics, Sidney Hillman Medical Center of the Male Apparel Industry of Philadelphia, 1952, mimeographed.

Table 6.—*Laboratory tests, Sidney Hillman Health Center, Philadelphia, fiscal year May 7, 1951–Apr. 30, 1952* [1]

Item	Number	
	Total	Average per 1,000 eligibles [2]
Laboratory tests	45,907	2021.3
Acid phosphatase	20	.9
Addis count	14	.6
Agglutination test	7	.3
Albumin globulin ratio	50	2.2
Alkaline phosphatase	33	1.5
Amylase	6	.3
Basal metabolism rating	461	20.3
Bence Jones protein	9	.4
Bleeding time	20	.9
Blood calcium	28	1.2
Blood chloride	3	.1
Blood cholesterol	286	12.6
Blood cholesterol esters	32	1.4
Blood creatinine	6	.3
Blood culture	1	[3]
Blood Kahn	124	5.5
Blood lypase	6	.3
Blood phosphorus	22	1.0
Blood sugar	2,827	124.5
Blood total bilirubin	20	.9
Blood type	5	.2
Blood urea nitrogen	1,210	53.3
Blood uric acid	108	4.8
Bromsulphalein	48	2.1
Carbon dioxide	3	.1
Cephalin flocculation	39	1.7
Coagulating time	19	.8
Culture for tuberculosis	28	1.2
Differential	4,899	215.7
Duodenal drainage	3	.1
Eagle flocculation	647	28.5
Eye culture	3	.1
Fasting gastric analysis	62	2.7
Feces examination	38	1.7
Feces for occult blood	54	2.4
Feces for ova and parasites	36	1.6
Fishberg test	43	1.9
Fractional gastric analysis	61	2.7
Fragility of red blood count	11	.5
Fungus culture	8	.4
Fungus (wet preparation)	8	.4
Gastric lavage for tuberculosis	1	[3]
Glucose	9	.4
Hematocrit	204	9.0
Hemoglobin	4,931	217.1
Hetrophill antibody	8	.4
Icterus index	23	1.0
Kline	903	39.8
Kolmer Wassermann	3,946	173.7
Mazzini	622	27.4
Mean corpuscular hemoglobin	1	[3]
Mean corpuscular volume	1	[3]
Mosenthal test	10	.4
Nasal smears for eosinophiles	182	8.0
Nonprotein nitrogen	5	.2
Phenolsulfonphthalein	34	1.5
Papanicolaou	35	1.5
Platelet count	65	2.9
Protein bromide iodine	15	.7
Prothrombin	23	1.0
Quantitative urine sugar	69	3.0
percent	94	4.1
Quantitative Wassermann	8	.4
Rh factor	4,931	217.1
Red blood count	1	[3]
Renal calculi	61	2.7
Reticulocyte count	2	.1
Retraction of clot	21	.9
Routine cultures	77	3.4
Routine smears	1,310	57.7
Sedimentation rate	12	.5
Seminal fluid	55	2.4
Sickling preparation	30	1.3
Smear for tuberculosis		
Smear for tuberculosis (urine)	8	.4
Smear for Vincent's	2	.1
Spinal fluid cell count	20	.9
Spinal fluid colloidol gold	19	.8
Spinal fluid protein	16	.7
Sputum concentration for tuberculosis	3	.1
Sputum culture	1	[3]
Sputum culture for tuberculosis	7	.3
Sputum examination	51	2.2
Sputum for tuberculosis	21	.9
Sputum for eosinophiles	6	.3
Stool culture	7	.3
Stool for amoeba	3	.1
Stool for fat content	2	.8
Thymol turbidity	19	.1
Tissue examination	18	.8
Total protein	55	2.4
Urea clearance	4	.2
Urinalysis	4,628	203.8
Urine culture	23	1.0
Urine protein	1	[3]
Urine tuberculosis culture	1	[3]
Urobilinogen	2	.1
VDRL slide	1,602	70.5
Vaccine	1	[3]
Vaginal culture	1	[3]
Van den Bergh (direct)	31	1.4
Van den Bergh (indirect)	18	.8
Venous coagulation time	3	.1
Venous punctures	5,438	239.4
White blood count	4,899	215.7

[1] Includes complete count of each type of test regardless of number received at any one visit.
[2] Based on average 12-month membership of 22,712.
[3] Less than 0.05 per 1,000.

Source: Monthly Statement of Statistics, Sidney Hillman Medical Center of the Male Apparel Industry of Philadelphia, 1952. Mimeographed.

Table 7.—*Physical medicine and rehabilitation treatments, Sidney Hillman Health Center, Philadelphia, May 7, 1951–Apr. 30, 1952* [1]

Item	Number		Item	Number	
	Total	Average per 1,000 eligibles [2]		Total	Average per 1,000 eligibles [2]
Physical medicine and rehabilitation treatments	22,849	1,006.0	Muscle reeducation	2,443	107.6
			Neuroelectric test	3	.1
Buergers exercise	286	12.6	Paraffin	442	19.5
Cyrotherapy	144	6.3	Peripheral vascular disease	69	3.0
De Loreme exercises	544	24.0	Pes planus	67	2.9
Exercise general	119	5.2	Postural exercise	2,692	118.5
Fluorescin test	3	.1	Radiant heat: luminous	403	17.7
Galvanic	39	1.7	nonluminous	3,086	135.9
Hydrocollator	23	1.0	Range of joint motion test	2	.1
Injection	925	40.7	Rapid sine	21	.9
Ionization	98	4.3	Sayer sling	966	42.5
Jolle's test	1	[3]	Short wave diathermy	2,139	94.2
Leg length	141	6.2	Sine	3,081	135.7
Manual muscle test	1	[3]	Therapeutic walk	535	23.6
Massage	3,844	169.2	Ultraviolet, Kromayer	16	.7
Moistaire	21	.9	Ultraviolet, air-cooled	111	4.9
			Whirlpool	584	25.7

[1] Includes complete count of each type of treatment regardless of the number received at any one clinic visit.
[2] Based on average 12-month membership of 22,712.
[3] Less than 0.05 per 1,000.

Source: Monthly Statement of Statistics, Sidney Hillman Medical Center of the male apparel industry of Philadelphia, 1952. Mimeographed.

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The Sidney Hillman Health Center of New York*

16 East 16th Street

New York, N. Y.

This is a group practice health center established in 1951 to provide health and medical services to ambulatory patients. Approximately 40,000 members of the 26 locals of the New York Joint Board of the Amalgamated Clothing Workers of America, CIO, and their wives are eligible for membership. About 33,000 persons have joined the plan; most of the 7,000 union members not participating reside outside the 5 boroughs in New York City, with several thousand living in New Jersey. The center is a cooperative project of the New York Joint Board of the Amalgamated Clothing Workers of America, CIO, and several organizations of manufacturers in the trade including the New York Clothing Manufacturers' Exchange. Union members and wives each pay an annual $10 fee to cover medical services and starting April 1953 employers pay one-fourth of 1 percent of payrolls. Until April 1953 members paid additional charges for special services. The average cost per eligible person, during the fiscal year 1951–52, was $10.38.

The first funds for the center were appropriated in September 1947 from a joint union-employer fund collected for various health and welfare purposes. The New York Clothing Manufacturers' Exchange, representing employers, assigned their share in $1,000,000 of this fund for construction of a health center. Both the union and the employer representatives participated in the planning. Various business and medical authorities in New York City also assisted in setting up the program. Mr. David Dreschler, counsel to the New York Clothing Manufacturers' Exchange served, and continues to serve, as counsel without remuneration.

Since the center could not be set up under the then-existing State law, special enabling legislation was passed in 1949 authorizing the establishment of the center as a membership, nonstock, nonprofit corporation. See exhibit A for comments of Mr. Dreschler on the previous legal difficulties. Exhibit B contains the enabling legislation passed by the New York State Legislature.

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*Louis Hollander, President, Health Center, and Co-manager, New York Joint Board of the Amalgamated Clothing Workers of America, CIO; David Dreschler, Legal Counsel for the New York Clothing Manufacturers Exchange and the Health Center; Morris Brand, M. D., Medical Director.

Basic objectives outlined by plan

1. Achievement of vigorous health for all members by combining medical services for the ill and preventive medical care for those who are well.

2. Maintenance of physician-patient relationship and of dignity of patient at all times.

Criteria used in establishing center:

1. *Group enrollment.*—Actuarially, this is a sound insurance principle and reduces the cost by spreading the risk.

2. *Prepayment of fee.*—Prepaying the fee assures the medical program of definite income, thereby assuring the members that service is available when needed, unhindered by a lack of funds in a moment of distress.

3. *Age and sex limitations.*—There should be no limitations because of age or sex.

4. *Service.*—The program should provide service rather than payment (indemnification), and the organization providing such service assumes the responsibility of establishing medical standards for its physicians and for the quality of care rendered. An indemnification program meets only part of the surgical and hospital expenses the member incurs.

5. *Unlimited service.*—Service should be available according to the patients' needs and not be restricted by an arbitrary number of services or other limiting factors.

6. *Preventive medical care.*—Members should have available to them and should be encouraged to undergo periodic health examinations and to participate in medical surveys, case findings and other preventive measures. Lack of attention to an apparently insignificant illness may lead to a catastrophic or lengthy and even chronic illness, and possibly complete disability. Prompt attention leads to early diagnosis and early treatment and in most instances to the avoidance of more serious complications.

7. *Medical standards.*—All standards for medical service and the selection of physicians of high caliber should be promulgated by a medical board.

Eligibility

Regular membership.—Membership is limited to members of the 26 locals of the New York Joint Board of the Amalgamated Clothing Workers of America. Participation by each local is dependent upon the acceptance of the plan by a majority of members in the local. All locals have elected to participate. Each member is assessed annually for membership dues, except those living in New Jersey for whom participation in the plan is voluntary.

Dependents.—Wives of members have been eligible on the same basis as members since March 1952. Children are not eligible, but the possibility of extending coverage to them will be considered.

Membership

The membership is composed of persons in various occupations in the clothing industry and is scattered throughout a large number of shops.

Average annual membership.—During the first 12 months, an average of 33,356 persons were eligible for services; and during the first

18 months (ending September 1952), an average of 32,468 persons were eligible.

Total membership.—At the end of September 1952, 18 months after the center opened, the membership was 30,692.

	Sept. 30, 1952
Total	30,692
Members	30,039
Wives	653

The low participation by wives is considered by the center officials to have resulted from the distances between the center and homes and from the low earnings of some members during 1952.

METHOD OF FINANCING AND COST OF CARE

Method of financing.—The center facilities and equipment were purchased with funds, totaling $1,000,000, allocated to the New York Joint Board of the Amalgamated Clothing Workers of America and the New York Clothing Manufacturers' Exchange from joint health and welfare funds. Such long-range expenses as replacement of equipment and provision against plant obsolescense are paid from the balance of the million dollar fund, now known as the general fund.

Each member of the local is assessed $10 a year and an additional $10 if his wife participates. The employers agreed to pay one-fourth of 1 percent of the payroll, starting April 1, 1953. Prior to April 1, 1953, nominal fees were charged for diagnostic and therapeutic radiological procedures, laboratory procedures (except initial screening laboratory examinations), physical medicine treatments, and medication. Except for medication, all charges have now been eliminated.

Operating expenses.—Operating costs of the program, excluding depreciation, were about $480,000 during the first 18 months of operation. Payments to the medical staff constituted about one-third of total costs; and salaries and fees of all the professional staff, about one-half of total operating expenses.

Average annual cost.—The average annual cost, per eligible person, of providing health and medical services was $10.38 during the fiscal year 1952. The cost excludes any allowance for depreciation of plant and equipment.

	Average cost Apr. 1951–52
Cost per eligible person	$10.38
Cost per patient	38.60

Payments to physicians.—Physicians received fees of $162,000 during the first 18 months of operation. The payment for general practitioners was $5 per hour and for specialists, $7.50 per hour. The average for all physicians on the center staff was $6.18 per hour.

SERVICES PROVIDED

Preventive, general medical and specialist's care is given at the health center. Services are provided only by appointment. A real problem has arisen from patients' failure to keep appointments. Cancellations and failure to appear range from 10 to 33 percent of all scheduled appointments, depending on such factors as the specialty involved, the weather, the industry's activities, rapidity of the patient's recovery, and the time lag between making the appointment and the date of service. Allowance is now made for unkept appointments by adding 15 percent more appointments per session. A weekly review of the appointment schedule is used as a guide for the addition of clinic sessions.

At present there is no waiting period for general medical appointments; for specialist care, an effort is made to provide service within a 2-week period.

General medical and specialist care.—Each new patient selects from 24 general practitioners one who becomes his personal physician. The personal physician has general supervision of the health of those who select him, conducts periodic health examinations, arranges for consultations with specialists and for laboratory services when necessary, coordinates their findings, and interprets them to the patients.

Patients are encouraged to have a complete physical examination during their first visit or to make a definite appointment for return for an examination. Thereafter, a periodic physical examination is given at the patient's request. It includes a photofluorogram of the chest, urinalysis, hemoglobin determination, serological test for syphilis, and cystological examination for cancer.

Specialists on the staff represent all the major specialties including surgery, although only minor surgery is performed at the center. See exhibit C for a description of the specialists' services provided.

Ancillary services.—X-ray services include diagnostic X-ray examination, with interpretation by a physician, and superficial and deep X-ray therapy. All standard laboratory procedures and physical therapy, including various types of treatment and corrective exercises, are available.

Cooperative services.—Diagnostic and consultation services are provided for members, with the results made available to the family physician, at the member's request.

The center issues a health education publication. A committee composed of representatives of the union and the center's medical advisory committee is drawing up plans for a broader health education program.

Arrangements have been made with the Mount Sinai and Jewish memorial hospitals for the diagnosis and treatment of certain types of illness with radioactive isotopes. Surgical and orthopedic appli-

ances and hearing aids are available at special rates through arrangements made with outside establishments.

The center provides counseling service and the assistance of a medical social worker to members in need of hospitalization and other referrals.

Other services.—The pharmacy fills prescriptions at near cost. Members are entitled to indemnification for hospital costs and surgical fees from the nationwide amalgamated insurance fund established through collective bargaining. Physicians at the center, if they are chosen by the patient to provide the service, have agreed to accept the insurance payment for surgical services in the hospital. The center has arranged with several hospitals to accept assignment of the insurance indemnity as full or partial payment for hospitalization, thereby eliminating the need for members to make complete payment before reimbursement by the insurance fund.

Services not provided.—The center does not provide surgical or medical care in the home or hospital, hospitalization, dental care, or psychiatric treatment.

Facilities

The center owns and occupies a six-story building with 36,000 square feet of floor space. The building is located near the union office and is in the center of the men's and boys' garment district. Four floors are now occupied. Extensive alterations were made to provide a modern building with 34 examining rooms and 60 dressing rooms. Special features include small waiting rooms and individual examining rooms. The pharmacy is located within the center. On June 17, 1953, the board of trustees of the center voted to spend $250,000 to equip one of the two additional floors that were available for expansion and for additional equipment in existing services.

The clinic hours are 9 : 30 a. m. to 6 p. m. on Mondays through Fridays and 9 : 30 a. m. to 12 : 30 p. m. on Saturdays. To the extent feasible, the appointment schedule has been correlated with work activities of members. Wives are given appointments only during morning and mid-afternoon clinical sessions so that all evening and Saturday appointments are available to workers.

Staff

Administrative staff.—The administration of the center is carried out by a medical director and a business manager. The center has four secretaries, including a medical secretary in the radiology department. The general clerical staff includes 1 receptionist, 1 registrar, 1 switchboard operator, 1 bookkeeper, 1 cashier, 1 stock clerk-messenger, 1 stock clerk-cashier, 2 appointment clerks, 3 station clerks, and 3 clerk-typists.

Maintenance of the center requires 1 supervisor, 3 porters, and 1 maid assigned to the laboratory.

Professional staff.—As of September 1952, the center had 73 part-time physicians, including 24 general practitioners and 49 specialists. In addition to the staff physicians, the center employs the following full-time ancillary personnel: 4 registered nurses and 1 nurses' aide, 2 X-ray technicians, 2 registered laboratory technicians, 2 registered physiotherapists, and 1 physiotherapy aide, and 2 pharmacists.

Medical records are kept by 1 supervisor assisted by a medical librarian, a medical stenographer, and 4 clerks.

Physicians' hours.—The monthly hours of service per physician range from 4 to 76. During the first 18 months, physicians provided 27,058 hours of service, 14,566 by general practitioners and 12,492 by specialists. Table 1 shows the number of physicians and the average number of physicians' hours per week, by specialty. The need for flexibility in the session assignments and the necessity for keeping costs to a minimum have made it premature to consider the employment of full-time physicians or to guarantee retainers to the staff. When the program is stabilized and experience indicates a definite pattern of weekly or monthly utilization, recommendations for tenure will be made.

Qualifications for physicians.—Physicians are appointed by the board of directors after recommendation by the medical advisory council. The medical advisory council has adopted the following standards for general physicians and specialists. "It is expected that each physician will maintain an active interest in the progress of medical science by attending approved postgraduate courses, clinical rounds and conferences at approved hospitals, and scientific meetings.

"Each physician must be a member in good standing of a medical society and is required to carry malpractice insurance." Malpractice insurance must be $25,000/$50,000 minimum.

A general practitioner must provide evidence that he or she—

A. 1. Has completed a general rotating internship for a period of at least 1 year in a hospital approved for a rotating internship by the American Medical Association.

2. Has a staff appointment in the in- or out-patient department of a voluntary or municipal hospital approved by the American College of Surgeons, or

B. If not qualified in accordance with "A" above, equivalent qualifications will be evaluated on an individual basis.

Each specialist shall provide evidence that he or she—

A. 1. Holds a certificate issued by the examining board in the medical specialty, and

2. Has an in- or out-patient staff appointment in the same specialty in a municipal or voluntary hospital approved by the American Medical Association for resident training in the specialty, or

B. Holds an appointment as an attending physician or associate attending physician, or assistant attending physician (or equivalent rank) on the staff

of a hospital approved by the American Medical Association for resident training in that specialty, or

C. If not qualified in accordance with "A" or "B" above, equivalent qualifications will be evaluated on an individual basis.

UTILIZATION OF SERVICES

Persons receiving care.—A large proportion of persons eligible for care visited the center during the first few months of operation. Postponed care and the desire for medical checkups, coupled with the closing of most of the industry's shops early in May 1951, were held responsible for the large initial demand for service. During the first 18 months, 46 percent of all eligible persons visited the center; as of September 30, 1952, 78 percent of the wives then enrolled had received care.

Number of persons making first visits to the center, April 1951–September 30, 1952:

Total	13,495
Members	12,988
Wives (since March 1952)	507

The number of patients making their first visits to the center during each of the first 18 months is shown in figure 3.

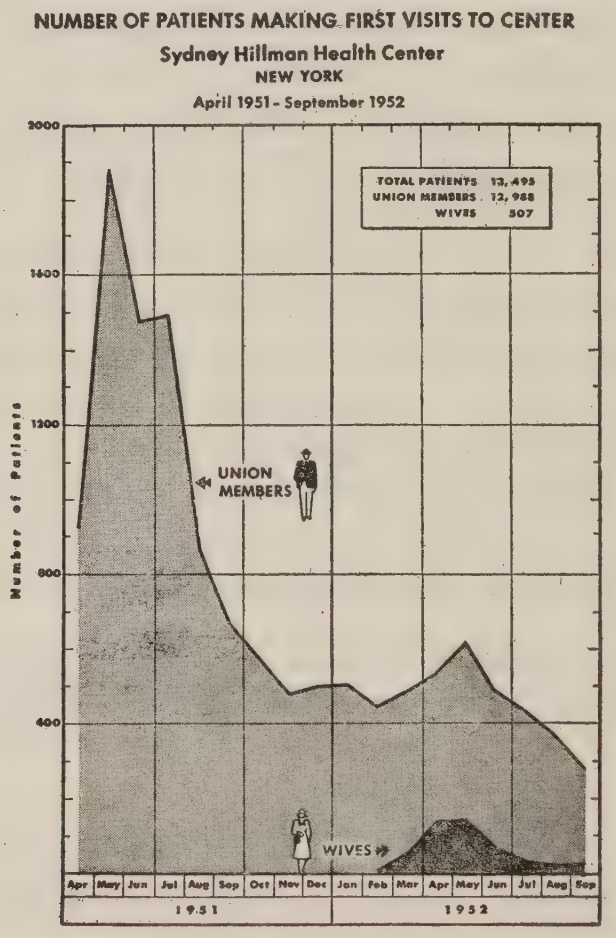

Figure 3.—Number of patients making first visit to center, Sidney Hillman Health Center, New York, April 1951–September 1952

Source: Brand, Morris A., M. D.: The Medical Service Program of the Sidney Hillman Health Center of New York. Presented at annual meeting of the American Public Health Association, October 1952.

The concentration of the center patients in the older age groups is shown in table 2; 77 percent of the patients were over 40 years of age, as compared with 65 percent of the men and women over 40 of the New York Joint board.

Total services provided.—During 18 months, 242,519 services were provided to the 13,495 patients, representing 18 services per patient. Each 1,000 eligible members received nearly 5,000 services per year, or 4,100 services if pharmacy prescriptions are excluded.

Of the approximately 243,000 services, nearly 98,000 were physicians' services. Each eligible person received, on the average, 2 physician services per year; each patient received over 7 physician services per year.

Diagnostic procedures totaled 81,000 during the 18-month period, an annual average of 1,665 per 1,000 eligibles. Ancillary therapeutic services were 22,000, or 445 per 1,000 eligible persons per year.

Item	Number of services	
	Total, 18 months	Annual rate per 1,000 eligibles [1]
All services	242,519	4,979.7
Physicians	97,938	2,010.9
General medicine	46,323	951.1
Specialists	51,615	1,059.8
Diagnostic procedures	81,098	1,665.2
Ancillary therapeutic services	21,672	445.0
Prescriptions	41,811	858.5

[1] Based on average monthly eligibles of 32,468.

Services by medical department.—Of all services provided by physicians during the first 18 months, 53 percent were provided by specialists; during the last 6 months of that period, 56 percent were by specialists. A breakdown of the number of services provided by month by specialists and by general physicians is shown in figure 4. The slight upward trend in the proportion of specialists' services may arise from continuing treatment by specialists of patients with chronic disease.

More services were provided by the eye department than by any other specialty, representing 14.8 precent of all specialists' services. Interpretation of X-rays and services of an allergist accounted for 14.3 and 13.4 percent, respectively, of all specialists' services. The number of services and the number per 1,000 eligibles, by clinic or department, are shown in table 3.

Services provided by ancillary departments.—About 9 percent of all diagnostic procedures were diagnostic X-ray examinations provided to about 15 percent of all eligible persons. Photofluorograms accounted for another 11 percent of diagnostic tests. Nearly 80 percent of the ancillary therapeutic services were physical therapy treatments. Deep

therapy was given about 4 times for every 1,000 eligibles and superficial therapy, 3 times for every 1,000 persons. Further details on diagnostic and ancillary therapeutic services will be found in table 4.

Administration

The center is administered by a nonprofit corporation setup under the laws of New York State. It is under the general supervision of the New York State Department of Social Welfare.

During the first year, many important administrative procedures were established or amended as experience was gained from the center operations. Some of those decisions directly affecting the membership are summarized in exhibit D.

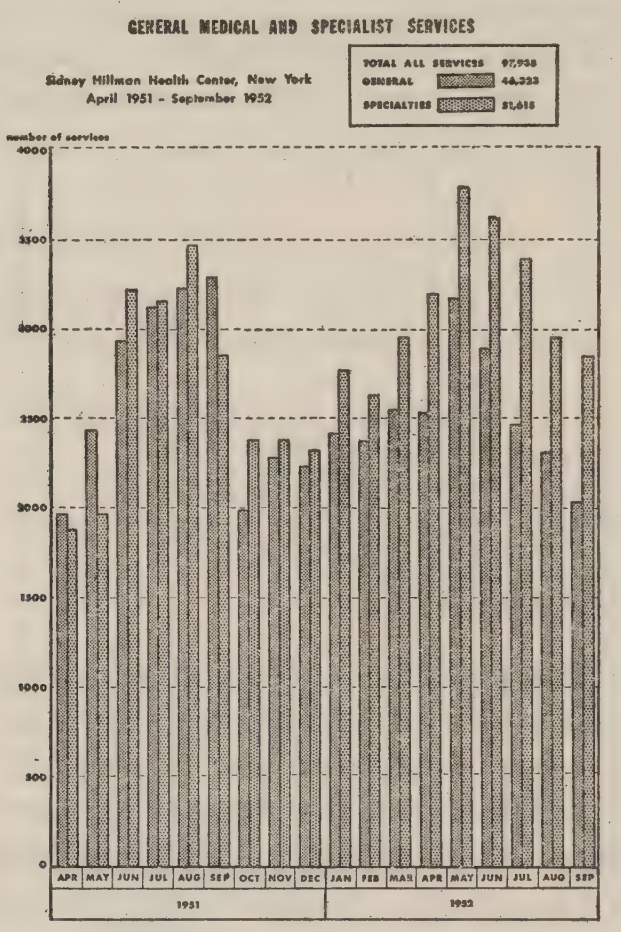

Figure 4.—General medical and specialist services, Sidney Hillman Health Center, New York, April 1951–September 1952

Source: Brand, Morris A., M. D.: The Medical Service Program of the Sidney Hillman Health Center of New York. Presented at annual meeting of the American Public Health Association, October 1952.

Board of directors.—Twenty-one members, including 15 from the union and 6 representing employers, elected by the corporation comprise the board of directors. The board is responsible for the general policy of the program, including election of the executive committee, designation of the medical director and the business manager, and appointment of physicians from a list of nominees approved by the medical advisory council.

Executive committee.—This committee consists of nine members composed of representatives of the union and industry, who act under authority delegated by the board of directors.

Medical advisory council.—Nine physicians, including the medical director and two other physician members of the staff, make up the medical advisory council, which formulates standards, rules and regulations for professional and technical services at the center, reviews physicians' qualifications, and recommends staff appointments. A summary of the activities of the council during the first year of the center's operation is given in exhibit E.

Medical director and busines manager.—Both are responsible to the board of directors for the joint administration of activities at the center.

Joint conference committee.—Composed of members of the executive committee, 3 members of the medical advisory council, the medical director and 2 staff physicians, the joint conference committee functions as an appeal forum to discuss medical matters affecting the center. The recommendations of the committee are referred to the board of directors for action.

Medical conferences are held 3 to 4 times a year to give the medical and administrative staffs an opportunity to review and evaluate past experience and to discuss problem areas.

Chiefs of clinics.—Three of the internists on the staff are designated by the medical director to be responsible for clinic sessions, to be available for conferences on diagnosis and treatment and for emergency consultations, and to act as substitutes for general practitioners unable to attend clinic sessions.

One clinic chief is responsible for reviewing the medical charts of the previous day's sessions for the purpose of evaluating the services rendered. Also, activities of physicians newly appointed to the staff are reviewed daily and findings discussed by the medical director with the physician.

In the opinion of the medical director, the clinic chief system has proved most useful. From September 1951 to September 1952, the clinic chiefs performed 17,873 services, including 7,300 chart reviews, 3,700 conferences with physicians, and 2,100 urgent consultations.

Records and research

Funds for research at the center were received from the New York Joint Board ($250,000) and from the Sidney Hillman Foundation ($50,000).

The research activities at the center are directed primarily toward determination of essentials for health rather than the causes of illness. To date, the principal project has been a study of the relationship of dietary and ethnic background to the occurrence of arteriosclerosis.

Other health and welfare benefits

Services at the center are supplemented by the union's social insurance program under collective bargaining.

Hospitalization.—Nine dollars a day up to 31 days for sickness and up to 62 days for accidents.

Surgery.—Up to $200.

Sick leave.—Twenty dollars a week up to 13 weeks for sickness and up to 26 weeks for accidents.

Maternity benefits.—One hundred dollars.

Life insurance.—Five-hundred-dollar policy.

Retirement.—Fifty-dollar pension at age 65, in addition to benefits under old-age and survivors insurance.

Various evaluations

In April 1952 the New York State Department of Social Welfare reported on the findings of a survey made of the health center. The survey revealed that ". . . all departments were functioning efficiently and with a degree of coordination that indicated careful planning." With respect to the professional care of patients the report stated: "The provision of well-qualified staff and an appointment system which enables the physician to devote sufficient time to each patient supply the basic requirements for a good medical care program." The center building and the equipment were favorably noted. The complete text of the department of social welfare's report is contained in exhibit F.

The president of the New York Clothing Manufacturers Exchange wrote in 1952: "The Sidney Hillman Health Center is everything good that is said of it in other pages of this book (Health Security by Union Action, 1952)—a memorial to a great man who would value its humane work more than the personal tribute to his name engraved on its wall. . . . The ill face their lot with erect self-respect knowing that they will receive the best that medical science can provide and that it is their due."

Exhibit A.—*Statement by David Dreschler, general counsel, New York Clothing Manufacturing Exchange and counsel for the Sidney Hillman Health Center of New York*

The history of the Sidney Hillman Health Center will be one of interest not only to the sociologist, viewing it as one more step made jointly by the New York joint board, the Amalgamated Clothing Workers of America, and the New York Clothing Manufacturers Exchange, in the field of social welfare, but also to the student of statutory law.

When the idea of a health center was conceived, it was assumed that it would be necessary merely to buy or erect a building, equip it with medical apparatus, and engage doctors to treat union members coming under the jurisdiction of the New York joint board.

It became clear to me, however, after conferences with the Attorney General and the board of social welfare, that the laws of New York State governing

institutions which provide medical services had not been written to accommodate the organization of the contemplated health center. Research disclosed that:

1. It was impossible to organize the center as a membership corporation because a health center was not specified in the membership corporation law as one of the institutions which could be so organized.

2. The center could not function as an unincorporated association because that would have constituted an unauthorized practice of medicine.

3. Nor could it be established as a dispensary under the social welfare law because of restrictions concerning the source of funds to operate the center.

There was only one recourse left to us—special legislation. The New York State Legislature was requested to create, by legislative act, a membership corporation under the name of the Sidney Hillman Health Center, Inc., which would be empowered to provide health services for union members . . .

Source: New York Joint Board, Amalgamated Clothing Workers of America: *Health Security by Union Action,* (May) 1952, pp. 1–62.

Exhibit B.—*New York State Legislature special enabling act; became law April 13, 1949, Sidney Hillman Health Center of New York*

SECTION 1. Louis Hollander, Anthony Froise, Abraham Miller, Murray Weinstein, William P. Goldman, Isidore Grossman, Julius R. Levy, and Isidore Wolrich, all being of full age, citizens of the United States and residents of the State of New York, are hereby constituted a body corporate in perpetuity, by the name The Sidney Hillman Health Center, Inc., as a membership, nonstock corporation to be operated exclusively for the objects and purposes hereinafter set forth.

2. The objects and purposes of the corporation shall be: To establish and maintain a health center to furnish any or all of the following: medical care, surgical care, optical and dental examinations, medical diagnosis, medical advice and treatment, medicine and apparatus, and other health services to ambulatory patients, all through duly licensed physicians, or in the case of optical examination, through duly licensed optometrists. The corporation shall furnish such care, treatment, services, and supplies only to employees covered by collective bargaining agreements between the New York Joint Board of the Amalgamated Clothing Workers of America (a labor organization affiliated with the Congress of Industrial Organizations), and the New York Clothing Manufacturers' Exchange, Inc. (a membership corporation composed of manufacturers of men's and boys' clothing), and to employees covered by collective bargaining agreements between said labor organization and various other employers or associations of employers, either gratuitously or for a compensation determined without reference to the value thereof. Such health centers shall not be established and maintained in the State of New York without the prior written approval of the state board of social welfare as to the adequacy of the facilities and standards of care of the health center, including adequacy of personnel, and such health center when established shall be subject to the supervision, visitation and inspection of the state board of social welfare. No part of the activities of the corporation will be carrying on propaganda or otherwise attempting to influence legislation.

3. The corporation hereby formed shall possess all the powers which by the general corporation law are conferred upon corporations and in addition thereto shall have all the powers and be subject to the restrictions which now or hereafter pertain by law to a membership corporation created by special law so far as the same are applicable thereto and not inconsistent with the provisions of this act.

4. The territory in which the operations of the corporation shall be principally conducted is New York City.

5. The principal office of the corporation shall be located in the county and city of New York.

6. The persons named in the first section of this act will constitute the first board of directors and the first members of the corporation. They, or a majority of them, shall hold a meeting and elect officers and adopt bylaws. The bylaws may, among other things, prescribe the number, qualifications and functions of the corporation's members and the manner of their selection; the number and qualifications of directors who shall manage the affairs of this corporation, provided that the corporation always shall have not less than 7 directors, of whom at least 1 shall at all times be a resident of the State of New York; the manner in which vacancies among the members, directors and officers, however caused, shall be filled; the method of amending its bylaws; and any other provisions for the management of the affairs of the corporation. The bylaws may provide for the appointment by the board of an executive committee of the board and shall define the powers of such executive committee.

7. This corporation is not organized or created, and shall not be maintained, or operated, for private gain or personal or pecuniary profit or benefit. The income and the property of the corporation from whatever source derived shall be applied solely toward the promotion of the objects of the corporation as above set forth; and no portion thereof or of the net income or earnings of the corporation shall be paid or transferred to or inure to the profit or benefit of any member, officer, director, or employee of the corporation or any private individual provided that nothing herein contained shall prevent the payment in good faith of reasonable and proper remuneration to any member, officer, director or employee of the corporation or to any other person for any services actually rendered to the corporation or the payment of interest on money borrowed.

8. The funds of the corporation shall be derived from one or more of the following sources: funds furnished by employers through the Sidney Hillman Health Center fund which is organized and operates under an agreement and declaration of trust, dated as of October 8, 1947, funds furnished by the New York Joint Board of Amalgamated Clothing Workers of America; payments made to the corporation by employees covered by collective bargaining agreements mentioned in section two of this act for care, treatment, services and supplies furnished them by the corporation, the amounts of said payments in no event to exceed the cost to the corporation.

9. This act shall take effect immediately.

Source: New York State Laws, 1949, chapter 584.

Exhibit C.—*Specialist services provided at Sidney Hillman Health Center, New York*

Internal medicine.—Diagnostic and therapy services; consultations with general practitioner on cases not responding to treatment.

Surgery.—For cases not requiring hospitalization.

Respiratory.—Early detection of such illnesses as bronchial asthma, pleurisy, lung abscesses, tuberculosis and cancer; treatment of minor illnesses.

Diabetes.—Detection, treatment, and instruction of patient in diets and use of insulin and proper care of self.

Gastroenterology.—Diagnosis and treatment of patients with disorders of the digestive system; any major disorders referred by general practitioner to specialist.

Cardiology.—Diagnosis and treatment of heart disorders, with instructions on proper living habits.

Ophthalmology.—Eye tests and prescriptions for glasses when needed. This is one of the most frequently used departments at center because good eyesight is especially important in this industry. Close relationship is maintained with other departments since conditions of eye are often found to give clue to health defects, such as diabetes and high blood pressure.

Allergy.—Diagnosis and treatment. Workers in clothing industry are said to develop frequently allergies to dust, wool, and machine oil.

Otolaryngology.—Diagnosis and treatment of ear, nose, and throat disorders. This is considered an important function of center. Experience at center indicates that most patients with hearing defects can be relieved.

Psychiatry.—Consultation services only; outside referral for treatment.

Physical medicine and rehabilitation.—Treatment of muscular defects resulting from accident or disease. Service is very important to workers in clothing industry where maintaining same position for long period and repetition of a particular motion tends to cause musculoskeletal defects.

Dermatology.—Diagnosis and treatment including use of X-ray and lamp therapy.

Orthopedics.—Diagnosis and treatment including use of deep X-ray therapy and appliances. Such services are frequently requested by workers whose work is of repetitive nature.

Proctology.—Diagnosis and treatment. Proctologist frequently consults with stomach specialists, gynecologist, and general surgeon since work is closely allied.

Urology.—Diagnosis and treatment including X-ray as well as urinalysis.

Neurology.—Diagnosis and treatment of abnormalities resulting from disease or injury; referral to psychiatrist if pyschological disturbance is indicated.

Peripheral-vascular diseases.—Diagnosis and treatment including minor surgery. Most frequent ailment is varicose veins; others include hardening of arteries in legs and inflamation of arteries or veins.

Gynecology.—Diagnosis and treatment. Gynecological examination part of general physical examination for all women visiting center.

Source: New York Joint Board, Amalgamated Clothing Workers of America: *Health Security By Union Action,* (May) 1952, pp. 1–62.

Exhibit D.—*Administrative procedures established and amended during first year, Sidney Hillman Health Center of New York*

1. A decrease in the charge for physical therapy treatments, drugs, X-rays, and laboratory services.
2. The elimination of charges for minor surgery, biopsies, and tissue examinations.
3. Improvement of the appointment system.
4. Revision of the Sidney Hillman Health Center membership card for 1952.
5. Revision of the allergy clinic procedures and method of charging.
6. Arrangements were made with the Mount Sinai and Jewish Memorial Hospitals for the diagnosis and treatment of certain types of illness with radioactive isotopes.
7. Arrangements were made for our members to purchase surgical and orthopedic appliances at special rates.
8. Discussions are in progress to facilitate admission of our members to hospitals.
9. Arrangements have been made to have electroencephalograms performed for the members at hospitals and by specially trained physicians at reasonable rates.

10. The joint board's arrangement for admission of members to the Deborah Tuberculosis Sanatorium has been incorporated in the center's referral program.

11. A working rapport has been established with the Altro Rehabilitation Service for referral of cardiac and tuberculosis patients for rehabilitation.

12. In order to assist those members who have difficulty in paying for medication and procedures, arrangements were made to accept part of the fee on account and for the payment of the balance on future dates. At the period ending March 31, 1952, a total of only $430 remained as accounts receivable. Experience had demonstrated that the members owing money will as a rule repay it as soon as they find it possible to do so.

13. Arrangements have been made with the hearing aid division of the Zenith Radio Corp. to provide Zenith hearing aids to our members at a special cost—after our otologists recommend referral for this appliance.

Source: *Annual Report of the Medical Director,* Sidney Hillman Health Center of New York, April 15, 1952.

Exhibit E.—*Activities of Medical Advisory Council during first year of operation, Sidney Hillman Health Center of New York*

The council held 10 meetings. Major subjects acted upon include the following:

1. Adopted rules of conduct governing the activities of the council.
2. Elected officers of the council.
3. Determined the scope of services.
4. Adopted professional standards for general physicians, specialists, and consultants.
5. Approved the physician's application form.
6. Adopted standards for comprehensive health examinations.
7. Assisted in the determination of fees for physicians' services.
8. Reviewed physicians' applications.
9. Adopted the policy that staff physicians accept the amalgamated insurance fund's schedule of fees for services performed outside the center to members and their enrolled wives.
10. Adopted a policy of impartial referrals of patients for services to be performed outside the center.
11. Determined extent of deep X-ray treatments to be rendered in the center.
12. Recommended that the pathologist be placed on a retainer basis.
13. Adopted a policy regarding performance of surgical procedures in the center or doctors' offices.
14. Adopted recommendations for performance of electrocardiograms, gold injections, bronchograms in the center.
15. Adopted a policy regarding the responsibility of physicians for referring patients for comprehensive examinations and laboratory screening tests.
16. Adopted a policy of numerical coding of diagnoses.
17. Adopted a policy regarding the charges to be made by the staff for first-aid treatment to compensable cases.
18. Recommended a cancellation fee when the center cancels a physician's session.
19. Adopted a policy as it applies to the collection of more than one indemnification fee for surgical procedure.

Source: *Annual Report of the Medical Director,* Sidney Hillman Health Center of New York, April 15, 1952.

Exhibit F.—*Findings and recommendations resulting from a survey by State of New York Department of Social Welfare, April 9, 1952, Sidney Hillman Health Center of New York*

Administration: We found all departments were functioning efficiently and with a degree of coordination that indicated careful planning. Effective procedures have been worked out so that any patient visiting the health center is able to derive maximum benefit for the time expended.

We were interested to learn that the board of directors has extended the privilege of use of the health center to the wives of workers in the men's clothing industry. We were also interested to note the degree to which the health center has been able to cooperate with workers who are under the care of private physicians. We refer to the policy of making diagnostic services at the Sidney Hillman Health Center available for patients who are receiving their medical care under private auspices and furnishing reports to the physicians involved. In general, administration and supervision were found to be good, and there is every indication that both professional and clerical staffs are united in an endeavor to give good care to those who are eligible to attend the Sidney Hillman Health Center.

Professional care of patients: The medical advisory council of the health center has given effective guidance to the board of directors by providing standards for the appointment of physicians and specialists to the staff. The provisions of well-qualified staff and an appointment system which enables the physician to devote sufficient time to each patient, supply the basic requirements for a good medical care program. Diagnostic and therapeutic facilities are suitable to the program of the health center and qualified technicians are employed in all special departments.

Nursing supervision is good and nursing coverage was adequate at the time of our visit. Any marked rise in daily attendance, particularly an increase in female patients, would seem to necessitate additional nursing personnel.

In general, well qualified staff are available in all fields contributing to a good health program, with the exception of medical social service and we understand that this service is to be added.

Plant and facilities: The Sidney Hillman Health Center Building has been successfully remodeled for its present needs and careful consideration has been shown for the comfort, privacy and convenience of patients. Modern furnishings and attractive colors contribute to a pleasant environment. All equipment is new and excellent in quality. Cleanliness and order are well maintained.

Source: New York Joint Board Amalgamated Clothing Workers of America: *Health Security by Union Action,* (May) 1952, pp. 1–62.

Table 1.—*Number of physicians serving at center and hours of service, by specialty, Sidney Hillman Health Center, New York, September 1952*

Specialty	Number of physicians	Average number of hours per physician per week	Specialty	Number of physicians	Average number of hours per physician per week
General medicine	24	5½	Orthopedics	5	4
Allergy	2	4½	Otolaryngology	4	3
Cardiology	2	2	Peripheral-vascular	2	2
Chest	2	2½	Physical medicine and rehabilitation	3	8
Dermatology	1	5½	Proctology	2	3
Diabetes	2	3½	Psychiatry	1	1½
Gastroenterology	2	3	Social hygiene	1	1
General surgery	1	2	Radiology	3	7
Gynecology	1	3	Radiotherapy	1	1½
Internal medicine	3	23	Urology	2	(6)
Neurology	2	3½	Pathology	1	2
Ophthalmology	6	8			

Source: Sidney Hillman Health Center of New York, 1953. Unpublished data.

Table 2.—*Age and sex of patients at Sidney Hillman Health Center,[1] New York, 1952*

Age group	Total		Males		Females	
	Number	Percent	Number	Percent	Number	Percent
All ages	1,300		918		382	
Below 20	2	(2)	0		2	(2)
20–25	35	2.8	21	2.3	14	3.6
26–30	74	5.8	49	5.3	25	6.8
31–35	77	6.0	56	6.1	21	5.6
36–40	112	8.5	81	9.0	31	8.2
41–45	93	7.2	56	6.1	37	9.7
46–50	126	9.8	63	7.0	63	16.5
51–55	177	13.8	108	11.7	69	18.1
56–60	239	18.2	177	19.2	62	16.3
61–65	198	15.3	158	17.1	40	10.5
66–70	127	9.8	114	12.4	13	3.4
71–75	35	2.8	30	3.3	5	1.3
Over 75	5	(2)	5	.5	0	

[1] Based on a sample survey.
[2] Less than 0.5 percent.

Source: Brand, Morris A., M. D.: *The Medical Service Program of the Sidney Hillman Health Center of New York.* Presented at annual meeting of American Public Health Association, October 1952.

Table 3.—*Number of physicians' services provided, by department, Sidney Hillman Health Center of New York, April 1951–Sept. 30, 1952*

Item	Number of physicians' services			
	First 12 months of operation		First 18 months of operation	
	Total	Per 1,000 eligibles [1]	Total	Annual rate per 1,000 eligibles [2]
Physicians' services, total	62,818	1,883.3	97,938	2,010.9
General medicine	30,972	928.5	46,323	951.1
Specialties, total	31,846	954.7	51,615	1,059.8
Allergy	3,318	99.5	6,964	143.0
Cardiology	561	16.8	880	18.1
Chest	155	4.6	246	5.1
Dermatology	1,594	47.8	2,366	48.6
Diabetes	775	23.2	1,225	25.1
Electrocardiography readings	3,573	107.1	5,540	113.7
Gastrointestinal	210	6.3	402	8.3
Gynecology	560	16.8	953	19.6
Internal medicine	383	11.5	645	13.3
Medical "L" (antiluetic)	259	7.8	412	8.5
Neuropsychiatry	720	21.6	1,211	24.9
Eye	4,754	142.5	7,669	157.5
Orthopedics	1,329	39.8	2,343	48.1
Otolaryngology	2,969	89.0	4,483	92.1
Peripheral-vascular	434	13.0	663	13.6
Physical medicine consultations only	1,822	54.6	2,796	57.4
Proctology	1,040	31.2	1,531	31.5
Radiology, diagnostic	4,739	142.1	7,416	152.3
Roentgen therapy consultation	62	1.9	86	1.7
Surgery	1,071	32.1	1,535	31.5
Urology	1,518	45.5	2,249	46.2

[1] Based on average of 33,356 eligible persons during first 12 months of operation.
[2] Based on average of 32,468 eligible persons during first 18 months of operation.

Source: Brand, Morris A., M. D., *The Medical Service Program of the Sidney Hillman Health Center of New York.* Presented at American Public Health Association annual meeting, October 1952.

Table 4.—*Number of diagnostic and ancillary services provided, Sidney Hillman Health Center of New York, April 1951–Sept. 30, 1952*

Item	Number of services			
	First 12 months of operation		First 18 months of operation	
	Total	Per 1,000 eligibles [1]	Total	Annual rate per 1,000 eligibles [2]
Diagnostic procedures: [3]				
X-ray examinations	4,678	140.2	7,416	152.3
Laboratory:				
Basal metabolism	185	5.5	314	6.5
Electrocardiograms	3,557	106.6	5,540	113.7
Chemistry, urinalysis, etc	36,433	1,092.2	58,868	1,208.7
Photofluorograms	6,374	191.1	8,854	181.8
Biopsies	79	2.4	106	2.2
Ancillary therapeutic services:				
Injections by nurse	1,832	54.9	3,892	79.9
Physical therapy and rehabilitation	11,067	331.8	17,437	358.1
X-ray therapy: [4]				
Superficial	51	1.5	138	2.8
Deep	127	3.8	205	4.2
Prescriptions	26,435	792.5	41,811	858.5

[1] Based on average of 33,356 eligible persons during first 12 months.
[2] Based on average of 32,468 eligible persons during first 18 months.
[3] Excludes electrocardiography and X-ray readings; these are included in physicians' services.
[4] Services started October 1951.

Source: New York Joint Board, Amalgamated Clothing Workers of America: *Health Security by Union Action.* May 1952; Brand, Morris A., M. D., *The Medical Service Program of the Sidney Hillman Health Center of New York.* Presented at American Public Health Association Annual meeting, October 1952.

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Union Health Center*
International Ladies' Garment Workers' Union*

275 Seventh Avenue

New York 1, N. Y.

First of the International Ladies' Garment Workers' Union (A. F. of L.) health centers, the New York center was established in 1913. The center provides unlimited health services to ambulatory patients who are members of 27 International Ladies' Garment Workers' Union locals in New York City area and limited services for their dependents. During 1952, 201,200 members were eligible for service.

The program was union sponsored and was originally financed by locals with payments from membership dues. Since 1945 the services have been financed with funds received for health and welfare benefits under collective bargaining agreements. Average annual cost for medical services was $6.27 per member in 1952.

In 1910, sanitary conditions in the garment trades were a major issue in a general strike of cloak and suitworkers in New York City. Peace was established by the Brandeis' award which provided for preferential union shops and a joint board of sanitary control, representing manufacturers and union leaders. Subsequent investigation by the New York State Factory Commission, revealed a poor state of health among garment workers. These findings were substantiated by a United States Public Health Service study by Dr. J. W. Schereschewsky.

To meet the health needs of garment workers, the Union Health Center was established by union leaders in cooperation with Dr. George Price, who served as director until 1942. The present director, Dr. Leo Price, succeeded his father at that time.

The original center occupied 2 rooms and 1 physician was in attendance several hours a day. The program was incorporated in 1917 and was granted a New York State license in 1930.

Basic objectives outlined by plan

Original objectives to which the center still adheres:

1. To furnish abundant medical care to members of the industry who, because of their low earning capacity, are unable to pay for good medical care from a private physician.

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*David Dubinsky, President, International Ladies' Garment Workers' Union; Joseph Breslaw, Chairman, Board of Directors; Frederick F. Umhey, Secretary, Board of Directors; Leo Price, M. D., Director.

2. To examine all candidates for membership in the union.
3. To supervise the medical aspects of the sick-benefit systems.
4. To act as the health education department of the union.

Eligibility

Most locals require 6 months of membership in the local. Dependents of members are eligible for care at moderate fees, e. g., $1.25 per physician visit.

At one time the center had arrangements to provide services to members of other unions, but the practice was discontinued a few years ago when demand for service to members increased.

Membership

During the calendar year 1952, an average of 201,200 persons, members of more than 25 International Ladies' Garment Workers' Union locals, were eligible for services at the center. The typical establishment in which members work has about 50 employees. Work is seasonal and the industry is highly competitive with the possibility of 400 to 500 failures yearly.

Seventy-five percent of the union members are women and a large percentage of the membership is in the older-age groups. A study made available in 1952 showed that 53 percent of the female New York members and 75 percent of the male members were over 40, as compared with 40 percent of the general population over 40 years of age. Further breakdowns of the age and sex groups show that 50 percent of the men and 26 percent of the women in the New York International Ladies' Garment Workers' Union locals are over age 50 and that 23 percent of the men and 6 percent of the women are over age 60.

Method of financing and cost of care

Method of financing.—Each participating local assumes financial responsibility for the medical services provided to its members and pays for them from collective bargaining funds. The local is charged approximate cost, according to a fee schedule, for each service rendered. The patient pays moderate fees for prescriptions filled at the center's pharmacy and for care of dependents.

Since July 1, 1952, all members have been entitled to unlimited medical service without charge; prior to that date, each member was entitled to a specified amount of credit for services at the center, the amount varying among locals. Throughout the years, credits were increased from around $5 to $30 annually.

During the 3-year period 1947–49, approximately 77 percent of the center's income came from fees paid by the locals, on behalf of members, from union-administered health and welfare funds; the balance came from cash fees for services and drugs, paid by members and their dependents. The center estimates that members' payments for care of dependents and for prescriptions will amount to less than 5 per-

cent of total income now that all union members are eligible to receive full services without charges.

Operating costs.—Operating costs during 1952 including administrative expenses, building upkeep and depreciation, were as follows:

Total expenditures	$1,484,051
Medical services	1,260,651
Sick benefit department	146,100
Pharmacy	77,300

Average cost per member.—The average cost of the program per eligible member in 1952 for medical services, drugs, and processing of sick benefit claims was $7.38; for medical services only, the average cost per member was $6.27. Included in these figures is the cost of service, provided at moderate fees, to 3,600 dependents who were patients at the center during the year.

Item:	*Average cost per member, 1952*
Total	$7.38
Medical services	6.27
Services for sick benefit claimants	.73
Pharmacy prescriptions	.38

Average cost per service and per patient.—The average cost of each medical service was $2.39 during 1952. The average cost of medical services for each patient (members and dependents) was $25.77. Medical services exclude pharmacy prescriptions and the cost of sick benefit certification. Including the cost of sick benefit certification, the cost for each member-patient was $28.97. This is the cost for which the local is billed; among the locals, the cost per member-patient ranged from $18.83 to $46.32.

Item:	*Average cost per service, 1952*
Medical services (at center)	$2.39
Sick benefit claims (per service)	2.40
Pharmacy (per prescription)	.52

Payments to physicians.—Full-time and part-time physicians are paid on an annual basis, which includes payment for holidays, vacations, and sick leave. In addition, they receive employer-paid hospitalization insurance.

Physicians on an hourly basis receive $5 to $7.50 per hour although a few physicians who are chiefs of specialty services receive more than twice as much.

Services provided

The center provides diagnostic, preventive and general and specialist medical care to ambulatory patients, and is responsible for processing of sick-benefit claims to be paid from union health and welfare

funds. See exhibit A for a detailed description of the services provided at the center.

General medical and specialist care.—Each new patient at the center is given a thorough physical examination with urinalysis, hemoglobin determination, blood serology, and miniature chest X-ray. The same examination is given annually as patients return to the center. A physician reviews the findings, explains them to the patient and determines treatment, referring the patient to other departments if further diagnostic tests or special treatments are necessary. The same physician coordinates the findings of these other departments.

The center has physicians in all the major specialties. Close attention is given to the care of chronic diseases, especially those afflicting older persons. For a complete list of medical specialties see table 1.

In 1950, the center established a followup department which keeps in touch with members found to have serious conditions and arranges for care at the center or assists in arranging for services through other facilities in the community.

Ancillary services.—Laboratory services are provided upon the request of the attending physician. They include, in addition to the procedures given in the initial examination, hematology, sedimentation rate, blood chemistry studies, gastric contents and feces analysis for occult blood and parasites, examination of bacteriological smears for tuberculosis, gonorrhea, trichomonas vaginalis and vaginitis. Determination of basal metabolic rates by the oxygen consumption method was replaced by the radioactive isotope (iodine uptake) method on May 18, 1953. Other diagnostic services include audiometer, basal metabolism, and electrocardiography.

Miniature chest X-rays are made during the patient's first visit to the center and annually thereafter for patients returning to the center. The center is equipped to give both superficial and deep X-ray therapy. Physiotherapy treatments are given to all patients needing such care; it is widely used as a measure to bring relief in numerous chronic conditions encountered.

Cooperative services.—The center has always maintained a health education program. During the early years of the center, staff members gave short talks in the shops dealing with health education; later, health committees were organized among the workers. The center still maintains, and continues to revise and enlarge, its program, which is under the direction of Miss Pauline M. Newman who has been associated with the center since it began operating.

When an active case of tuberculosis is found, fellow workers of the patient usually report for a checkup in an effort to find the source of the case or cases. Throughout the years, the tuberculosis rate, which was high among members of the garment industry, has been greatly reduced.

Other services.—The center organized a nutrition department in 1947. Nutritionists see patients both individually and in groups. Upon request of the physician, a nutritionist interviews patients and helps them make the necessary adjustment in eating habits. The nutritionists have worked especially closely with patients in the diabetic, cardiac and gastrointestinal clinics.

A social service department aids members requiring help with special family problems and assists members in obtaining health services not provided at the center.

The pharmacy, located in the center, provides prescriptions at moderate cost.

The center certifies members for temporary and partial disability and since 1949 has certified members of the cloak section of the ladies garment workers industry for retirement on the basis of total and permanent disability. See exhibit B for details.

The center formerly conducted premembership examinations for most union members. This once important function is now carried on by only three small local unions.

Services not provided.—Home care and medical and surgical services in the hospital are not provided. However, patients at the center are eligible for cash benefits for hospitalization and for inhospital surgical and maternity benefits through the union health and welfare funds.

Facilities

The center moved to its present location in 1934 and purchased the building in 1945. It occupies six floors with about 100,000 square feet of floor space. Facilities include 55 modern examining rooms, including special suites for multiple clinics in such services as eye, chest, heart, and urology; physical therapy, X-ray and laboratory departments. The pharmacy is equipped to fill more than 600 prescriptions daily. A nutrition suite includes class rooms and a demonstration kitchen.

The center is open from 9 a. m. to 7:30 p. m. on Mondays through Fridays and from 9 a. m. to 2 p. m. on Saturdays. Dependents are cared for only during morning and afternoon hours.

Staff

The center has a staff of about 415 persons. With the exception of most of the physicians, the staff serves on a full-time basis.

Administrative staff.—Responsibility for the operation of the health center is delegated to the director. He is assisted by a staff of 14 department heads and 3 medical administrators. In addition, the center employs 130 clerks and registrars and 30 stenographers and typists.

Professional staff.—The center has a staff of 166 physicians, including 11 full-time and 12 half-time physicians. The remaining physi-

cians serve on an hourly basis. About 40 percent of the physicians are assigned to the department of general medicine and another 10 percent to the sick-benefit department. However, some of those assigned to general medicine also serve in a specialty service, and most of those in the sick benefit department do some work in the general medical clinics.

Department	Number of physicians	Department	Number of physicians
General medicine	67	Orthopedics	4
Eye	17	Neurology	4
Gynecology	6	Proctology	4
Ear, nose, and throat	10	Peripheral vascular	3
Allergy	3	Physiotherapy	1
Arthritis	4	Sick benefit	16
Chest	3	Skin	7
Diabetes	3	Surgery	3
Gastrointestinal	4	X-ray	3
Genitourinary	4		

The ancillary staff of the center numbers 76 and includes 38 nurses and aides and 28 X-ray, physiotherapy and laboratory technicians. All the ancillary staff is on duty 39 hours per week.

	Number		*Number*
Nurses and aides	38	X-ray, physiotherapy and laboratory technicians	28
Nutritionists	2	Pharmacists	5
Health educators	1	Social service worker	2
Record librarians	1		

Total physicians' hours scheduled at the center (excluding administrative hours) equal 1,366 per week or 1,226 hours excluding physicians' time spent in sick benefit certification. General medicine accounts for 52 percent and eye care for 13 percent of the scheduled clinic hours. See table 1 for a weekly schedule of physicians' hours at the health center.

Utilization of services

Persons receiving care.—During 1952, 45,312 members and 3,600 dependents received medical services at the health center. Sick benefit certifications were made for 27,000 members, many of whom also received medical care. The center officials estimate that a total of about 60,000 different persons visited the center during 1952.

There was wide variation among the locals in the proportion of their membership receiving medical services at the center.

	Percent
All locals	22.5
Local with highest rate of utilization	59.4
Local with lowest rate of utilization	5.5

Total services provided.—During 1952 the center provided 504,009 medical services to 45,312 member-patients and to 3,600 dependents.

On the average each patient received 10.3 medical services. Union members had a slightly higher rate of utilization than dependents.

Item:	*Average annual number of medical services per patient, 1952*
All patients	10.3
Union members	10.5
Dependents	8.5

Although the union members were entitled to unlimited services at the health center for the last six months of 1952, the number of medical services provided increased less than one percent over the 1951 levels. About 475,000 services were provided for union members, an average of 2,360 services per 1,000 eligible union members. Twenty percent of the total medical services were provided by the department of general medicine and an additional 29 percent by the various medical specialties. The remaining services were therapeutic or diagnostic procedures and special services, such as medical interviews, minor surgery and certifications for disability retirement.

Item:	*Number of services, 1952*
All medical services	504,009
General medicine	101,739
Medical specialties	146,103
Therapy	54,109
Diagnostic procedures	157,750
Special services	44,308

In addition to medical services, the center provided 61,869 services for sick benefit claimants (308 per 1,000 eligible persons) and the pharmacy filled 147,984 prescriptions.

Services provided by medical departments.—Union members and their dependents received nearly 250,000 physicians' services during 1952. Physicians' services for union members probably amounted to about 233,000 or roughly 1,200 physicians' services per 1,000 eligible members. A little less than 60 percent of all physicians' services were given in the specialty clinics. The eye clinic was the most frequently used, although services in the allergy and hay fever clinics combined exceeded those in the eye clinic, a pattern which has been maintained over the past six years. See table 2 for a detailed presentation of all physicians' services from 1947 through 1952.

Services provided by ancillary departments.—Laboratory procedures and diagnostic X-ray accounted for 56 percent of all ancillary medical services in 1952. Other services which in 1952 accounted for at least 5 percent of total ancillary medical services were physical therapy and injection therapy treatments and medical interviews. Table 3 shows the number and type of ancillary services for 1947 through 1952.

Administration

Full responsibility for financing and operating the center was assigned to the International Ladies' Garment Workers' Union general executive board by participating locals in 1934. The Union Health Center committee made up of union officials appointed by the board, is responsible for overall policy.

The medical director, appointed by the Union Health Center committee, administers the center with the assistance of a medical council of eight physicians, with long experience at the center. It meets regularly with the medical director and several times a year with the union health center committee of the International Ladies' Garment Workers' Union general executive board.

The medical board, composed of the head of each medical service and three physicians representing the general practitioners on staff, meets regularly to develop standards and criteria for recording findings, to recommend modifications in the drug formulary, types of laboratory examinations to be performed, and many other procedures of vital importance to the center and its patients.

Records

Medical records for each patient are kept in a central file. The register of serious conditions, inaugurated in 1950, permits patient followup. And when funds permit will provide the basis for detailed analysis of specified conditions.

Other health and welfare benefits

Union locals bargain separately for other health and welfare benefits. For more detailed information on hospital and surgical benefits available to members of each participating local, January 1953, see table 4.

Hospitalization.—For most locals the indemnity payments are $5 a day. The maximum number of compensable days ranges from 21 to 75.

Surgical care.—Most locals have a maximum surgical allowance of $50. Several locals provide additional allowance for deliveries.

Sick benefits.—Members are eligible for sick benefits under the New York State temporary disability law.

Retirement.—Maximum of $50 a month except for cloakworkers who receive maximum payments of $65 per month.

Life insurance.—One thousand dollars for each member of all locals.

Various Evaluations

The New York State Department of Social Welfare evaluates the program of the Union Health Center periodically.

In 1947, the department's report stated: "The Union Health Center is an outstanding medical institution for the treatment of ambulatory

patients. . . . In terms of individual consideration of patients, it is unlikely that the Union Health Center is excelled by any other institution. . . . From our observation during the present survey and in our past visits it is apparent that patients receive good medical care in the sense that prompt, courteous and thoughtful service is given by qualified practitioners."

In 1952 the department commented particularly on the followup program inaugurated in 1950. The report noted that ". . . considerable development has taken place in the program of professional care for patients. We refer specifically to the development of a followup program which has most favorably affected patient care at the health center, and has expanded the case finding aspects of the medical care program. . . . This type of medical review adds to the value of the Union Health Center for those who are eligible to use its facilities, and the results of this intensive followup should be an important contribution in the field of public health and preventive medicine. . . . The Union Health Center continues to give good professional service to those who are eligible to use its facilities."

The full text of the 1952 statement will be found in appendix C.

Exhibit A.—*Report on selected activities, International Ladies' Garment Workers' Union, Union Health Center, New York City*

AMBULATORY MEDICAL SERVICE

Medical service on an ambulatory basis, which was instituted at the inauguration of the Health Center in 1913, has proved helpful to solve the greater majority of the medical problems of the worker. This is particularly so when this medical service incorporates a highly developed program of preventive medicine and conservative treatment to maintain the health of the worker.

From the experience of this institution, more than three-fourths of the medical service needed by a working population can be given at a Union Health Center. The remaining 25 percent of needed service, which includes home care and hospitalization, is not wholly met.

However, the service at the center is supplemented by cash subsidies to help cover the costs of hospitalization, catastrophic illnesses, and prolonged invalidism among older and chronically ill workers. Cash subsidies in themselves may not always be sufficient to cope with such problems. Nevertheless they are of considerable assistance to a working population which wishes to prepay the cost of its medical requirements, without recourse to charity.

While the goal of comprehensive service must ever be the aim of a labor organization—for the improvement of the health of its own workers as well as the nation's population—the International Ladies' Garment Workers' Union has taken the realistic attitude of utilizing every advantage in the local community service situation to secure adequate medical protection for its members.

A practical approach such as this, combined with the changing attitudes of the medical profession toward prepaid medical care, fostered by recent social progress in the health field, makes it possible for working people to secure a large amount of health security.

SCREENING PROCEDURES

Much unsuspected pathology has been uncovered by routine chest X-rays and routine laboratory tests performed for every patient. Routine X-ray is a pre-

ventive medical measure which often uncovers pathology before it develops into serious conditions.

About 30,000 miniature chest X-rays are taken each year for International Ladies' Garment Workers' Union members at the center. In 1 year X-ray readings of these films suggested approximately 5,000 abnormalties of the heart and blood vessels; 38 active tuberculosis cases were ultimately diagnosed from 1,482 films which had significant shadows requiring persistent followup and reexamination. In addition, the miniature X-rays suggested 82 tumors of the lung, 1,000 other lung conditions of varying significance and 200 findings in the mediastinum, of which 76 were considered thyroid glands located in the chest instead of in the neck.

Three laboratory examinations: urinalysis, blood count, and blood test for syphilis, are performed for each new patient. Unsuspected cases of diabetes and anemias are uncovered daily in this way. Sickle Cell anemia and Mediterranean anemias have been found among the workers originally from southern states, Puerto Rico or Mediterranean areas who are now employed in the New York City garment trades.

Eye service

Workers in the needle trades are greatly in need of competent eye service since their skill and productivity and therefore their income depends upon their vision.

In many crafts the operating distance at which the worker must see clearly is different from his reading distance. His glasses must be adjusted for these differences and must be ground so that proper vision correction is obtained. Since the Union Health Center ophthalomologists are acquainted with the requirements of the various crafts, refractions done at the center are more likely to be helpful from an occupational point of view.

Social service

The social service department aids International Ladies' Garment Workers' Union members requiring special help with family problems such as an invalid parent or personal problems of adjustment to a difficult life situation and mental illness. In addition, this service assists members needing hospitalization for acute illness, convalescent care, and other situations with which the average individual cannot cope.

The social service department makes full use of the welfare and health agencies of New York City in the solution of these problems.

Pharmacy

Equipped to provide as many as 600 prescriptions daily. A formulary, prepared by the medical board's formulary committee, lists medications that can be received from the pharmacy. The list contains about 200 items and is reviewed and revised periodically.

Nutrition

Good nutritional advice supplements the medical service rendered at the center.

Two nutritionists interview patients upon the order of the clinic physicians to discuss diets and help the person make the necessary adjustment in his eating habits to improve his health. Patients at the center respond well to this painstaking assistance with nutritional problems. Return visits requested by the nutritionist are kept and diet adjustments are usually achieved. A great need exists for more nutritional education, so that poor eating habits may be replaced by health producing ones.

Surgical control

The Union Health Center maintains the equivalent of a hospital outpatient service and therefore has never had a primary interest in surgical procedures.

Nevertheless, in view of the volume of serious conditions encountered among patients, it makes certain that patients needing surgery receive proper treatments.

Its concern is to see that the patient gets needed surgery from a qualified surgeon in a proper institution irrespective of whether or not the surgeon is a member of the center staff. It sees that the patient has an opportunity to choose his own surgeon, even though he may receive advice concerning surgery at the center. To this end the center cooperates fully with the medical profession and the hospitals in the community. A procedure of administrative control is in effect at the center to accomplish these objectives.

Register of serious conditions

The center focuses attention upon members who have a serious illness which requires special medical attention. Since 1950 the work has been done by means of a followup department which keeps in touch with members who are found to have serious conditions. This department strives to arrange for immediate treatment so that deterioration, to the detriment of life and health, is prevented or postponed.

The center's responsibility is to see that these members are properly cared for, either with its own facilities or through a community agency.

Cancer and other malignant growths.—The cancer register was set up in November 1950. It now has 620 cases on register, many of which are under constant followup. Others have been hospitalized and operated upon, or have died since being registered. Biopsies: 1,213 specimens of tissue have been taken during the last 2 years at the center for microscopic study. Seventy-seven proved to be cancer, needing immediate treatment, and 133 were noncancerous growths which were placed under medical observation and constant followup.

From references to the X-ray department, many new growths have been discovered. In 1952 from gastrointestinal X-ray studies, from urological X-rays, from chest X-rays, and from long bone studies, 102 tumors were diagnosed, of which 57 were cancerous.

Many cases of cancer of the breast have been diagnosed and referred for operation among the large population of women attending the center. In every case the center was able to see that immediate treatment was secured. Operated cases are vigilantly supervised to guard against metastatic spread.

Diseases of the blood.—Diseases of the blood also constitute a phase of control in the followup department. Of 273 cases of blood abnormalities registered, 36 were grouped as leukemias and polycythenias.

Diabetes.—A diabetic control program has been put into effect during the last 3 years with cases culled from an active file of about 70,000 medical records. Laboratory reports showing the presence of sugar in the urine were followed up and 2,005 cases of diabetes were uncovered.

Of 225 cases among this group, one-third did not have previous knowledge of sugar in their urine before coming to the center. It is difficult to estimate the number of unknown diabetics among the garment worker population in New York City, but it may be that as many as 2 persons out of every 100 garment workers have diabetes and many are unaware of this fact.

Heart disease.—Many garment workers show evidence of heart abnormalities, but of these only a small percentage need to have constant attention in the cardiac service. Enlarged hearts are not an uncommon finding in miniature chest X-ray routine service, verified by physical examination, by 14 by 17 films, and electrocardiograms.

Seventy-five percent of the workers with heart disease attending the cardiac clinic are working in the industry, and over 90 percent of the cardiac members are over 40 years of age. Members who have suffered a heart attack can often

return to work after reasonably short periods of convalescence providing they receive medical support and are able to rest adequately in slack seasons. The seasonal employment in the garment trades is an aid to cardiac workers since it permits them to rest without detriment to their employment.

Gynecology.—The need of such service to older age women is obvious. Besides functional disturbance, the high frequency of surgical treatment is carefully curtailed by conservative policy.

Tuberculosis.—A total of 5,314 tuberculosis cases are registered as either healed, arrested, or cured. These cases are reviewed and called back for supervision as is found necessary. Followup procedures have been developed that reduce supervision to a minimum and avoid loss of time from work for the member.

Active cases of tuberculosis discovered in the clinics or through routine X-ray receive prompt attention. A relationship is maintained with three sanatoria where every effort is made to insure the speedy admission of patients with tuberculosis and their return to the industry under medical supervision.

Source: Report of Union Health Center, International Ladies' Garment Workers' Union, covering years 1950–52, January 1953. Unpublished data.

Exhibit B.—*Processing of disability and sick benefit claims, International Ladies' Garment Workers' Union, Union Health Center, New York City*

Retirement for disability

In 1949 the cloak joint board extended its pension program (for 65-year-old members who wish to retire from the industry) to cover members 60 years of age or older whose physical infirmities prevent them from carrying on their work. The center was asked to determine which applicants for premature retirement were totally and permanently disabled.

A total of 356 workers have applied for disability retirement. Two hundred and thirteen of these applicants were totally and permanently disabled; 63 were not considered totally and permanently disabled; and 18 have been deferred for further examination at a later date to determine whether the disability is permanent.

Nineteen members died before examination and 29 totally and permanently disabled members died after they were pensioned.

As might be expected from the age of the applicants, the greatest number of members was found to be suffering from diseases of the heart and circulatory system. The second largest group had visual defects resulting in occupational blindness. Many advanced cases of arthritis were retired and members suffering from Parkinsonian syndrome (characterized by constant involuntary tremors) were found totally and permanently disabled.

Sick benefit

The number of sick benefit claims increased 9 percent between 1950 and 1951, but the number of claims in 1952 showed little change from the year before.

The State law insuring payment for disability from nonoccupational illness has developed problems. Formerly sick-benefit certifications were completely controlled by the objective medical examination performed by a center physician. Many of the present conflicts arise from a variety of obsolete bylaws and constitutions governing sick benefits. A review of the entire system should be instituted, since the establishment of new procedures and new constitutions seems to be the only way these problems can be solved properly.

Source: Report of Union Health Center, International Ladies' Garment Workers' Union, covering years 1950–52, January 1953. Unpublished data.

Exhibit C.—*Findings of New York State Department of Social Welfare Survey, International Ladies' Garment Workers' Union, Union Health Center, New York City, April 1952*

A program of remodeling and expansion was only just completed at the time of our last survey. We therefore found few changes in the physical plant during our present survey except for necessary renewals and replacements. Considerable development has, however, taken place in the program of professional care for patients. We refer specifically to the development of a followup program which has most favorably affected patient care at the health center, and has expanded the case finding aspects of the medical care program. The review of the complete medical record for each patient who has had a laboratory or X-ray test on which an abnormal finding is reported, appears to be an excellent method of ascertaining those patients for whom intensive followup is needed. This review also serves to evaluate and coordinate medical findings. In addition, a careful screening of the PFX films for chest conditions other than tuberculosis, has proved of great value in revealing conditions of which the patient has many times been unaware but which are urgently in need of medical attention. This type of medical review adds to the value of the Union Health Center for those who are eligible to use its facilities, and the results of this intensive followup should be an important contribution in the field of public health and preventive medicine.

It was noted that the staff of administrative physicians has been increased, both to cover the followup review and to facilitate direct service to patients who may require immediate attention from a physician, but who do not necessarily need to receive clinical care at the moment. We also learned that there have been increases of staff in other departments which contribute to the total picture of patient care, including an assistant to the medical social worker, and to the nutritionist, respectively.

While the number of registered nurses has not increased, the employment of aides for nonnursing duties has actually increased the available nursing coverage. There has also been real improvement in the area of nursing supervision, and in this connection, we note that a procedural manual for the nursing staff is nearing completion.

The Union Health Center continues to give good professional service to those who are eligible to use its facilities.

Source: Union Health Center, New York, 1953. Unpublished data.

Table 1.—*Weekly time schedule of physicians' hours, Union Health Center, New York, 1953*

Department	Total scheduled hours per week[1]	Number of physicians	Number of scheduled hours					
			Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
General medicine	640½	67	138½	132	111½	108½	70	80
Eye	160	17	33	27	31	19	28	12
Gynecology	25½	6	2	2	6½	---	12	3
Ear, nose, and throat	46	10	8	10	8	10	7	3
Allergy	43	3	6	9	7	6	8	7
Arthritis	34	4	3	8	6	6	5	6
Chest	24½	3	6	7½	6	5	---	---
Diabetes	20	3	4	6	2	3	5	---
Gastrointestinal	15	4	---	2	5	5	3	---
Genitourinary	17	4	2	7	4	2	2	---
Neurology	21	4	2	5	3	11	---	---
Orthopedics	32	4	5	7	5	6	3	6
Proctology	18½	4	2	4	6	4½	2	---
Peripheral-vascular	22	3	5	3	5	3	6	---
Physiotherapy	18	1	3	3	3	3	3	3
Sick benefit	139½	16	25½	33	22½	25	29½	4
Skin	40	7	6	6	9	8	11	---
Surgery	17	3	3	2	5	4	3	---
X-ray	32½	3	6½	6½	6½	6½	6½	---

[1] Excludes administrative hours.

Source: Union Health Center, New York, 1952. Unpublished data.

Table 2.—*Physicians' services provided in general medicine and specialty clinics, Union Health Center, New York, 1947–52*

Clinic	1952	1951	1950	1949	1948	1947
Total[1]	247,842	238,033	221,983	212,405	179,090	142,795
General medicine	101,739	98,343	90,451	89,691	74,116	59,445
Medical specialties	146,103	139,690	131,532	122,714	104,974	83,350
Allergy	24,887	20,646	17,487	16,287	13,080	12,252
Arthritis	6,222	5,997	6,306	6,957	5,826	4,832
Cardiology	1,216	1,290	990	919	665	---
Chest	2,504	2,162	3,369	2,416	1,768	1,556
Dermatology	9,764	8,746	6,809	6,569	4,374	3,023
Diabetes	3,383	3,315	2,785	1,941	1,044	---
Ear, nose, and throat	13,943	13,125	12,091	11,739	10,085	8,232
Eye	25,414	25,138	25,554	25,127	21,478	18,113
Gastrointestinal	1,406	1,456	1,075	634	246	206
Hay fever	17,782	17,170	17,101	15,835	15,613	13,526
Health maintenance	---	401	474	28	---	---
Neurology	1,447	1,333	1,202	1,396	1,336	815
Orthopedics	6,549	6,123	5,291	4,769	3,463	2,821
Minor gynecological surgery	2,268	2,547	1,674	1,136	757	615
Peripheral-vascular	3,714	4,285	4,005	3,050	2,270	1,981
Proctology	3,839	3,899	4,156	3,561	3,128	2,251
Social hygiene	2,079	2,711	3,982	5,383	7,398	5,231
Urology	3,872	4,007	4,273	4,158	3,872	3,670
Gynecology consultation	1,979	1,593	1,607	1,187	962	284
Physiotherapy consultation	10,639	10,815	8,555	7,616	6,225	2,657
Surgical consultation	3,196	2,931	2,746	2,006	1,384	1,285

[1] Excludes sick benefit referrals.

Note: Number of workers to whom these services were available averaged 200,000 annually during the 6 years, the year-to-year variation being nominal.

Source: Union Health Center, New York, 1953. Unpublished data.

Table 3.—*Ancillary services provided at Union Health Center, New York, 1947–52*

	1952	1951	1950	1949	1948	1947
Diagnostic procedures	157,750	160,077	157,641	142,223	103,875	75,493
Audiometer	269	240	231	263	227	151
Basal metabolism	1,703	1,785	1,802	1,648	1,486	1,465
Electrocardiography	10,245	10,089	8,479	7,395	6,597	4,366
Laboratory	90,820	95,025	93,107	91,650	68,701	51,321
Miniature chest X-ray	31,111	30,114	33,083	23,013	11,857	6,394
X-ray	22,793	22,068	20,316	17,854	14,762	11,796
Biopsies	809	756	623	400	245	----
Ancillary therapeutic services	54,109	56,695	55,500	50,063	50,897	34,446
Physical therapy	37,645	39,613	40,758	36,262	20,789	24,298
Injection therapy	13,782	14,743	12,806	13,318	----	10,148
Superficial X-ray	844	775	775	230	----	----
Deep X-ray	1,838	1,564	1,161	253	----	----
Other services	44,308	44,918	41,468	33,749	29,093	22,556
Medical interviews	32,426	32,533	31,605	27,458	23,968	18,652
Pre-membership examination	679	626	859	1,711	1,398	1,505
Emergencies	291	281	268	346	222	135
Nutrition	6,845	7,523	5,098	2,218	2,024	1,137
Social service	3,668	3,609	2,236	1,628	1,215	880
Special gynecological	----	----	1,115	----	----	----
Other	399	346	287	388	266	247
Prescriptions	147,984	144,920	133,409	123,567	103,769	80,616
Sickness insurance	61,869	61,649	55,818	48,488	47,306	41,595
Office certification [1]	26,207	26,321	22,450	20,558	19,469	19,674
District certifications	35,662	35,328	33,368	27,930	27,837	21,921

[1] Includes sick benefit referrals to diagnostic and specialty clinics.

See Note, table 2.

Source: Union Health Center, New York, 1953. Unpublished data.

Table 4.—*Hospital, surgical, and maternity benefits available to members of the International Ladies' Garment Workers' Union, New York City, Jan. 1, 1953*

Union	Hospital			Surgical (maximum allowance)	Maternity [1] (maximum allowance)	Eligibility requirements for new employees [2]
	Daily rate	Maximum duration	Extras (maximum allowance)			
Cloak joint board	$5	60 days per year	None	$50	None	6 months union membership and covered employment.
Dress joint board	5	75 days per year	do	$50	Special grant: $50	6 months union membership and in industry.
Local 10 (cutters)	5	60 days per year	do	$50	None	Do.
Local 20 (waterproof garment workers)	5	30 days per year	do	$50	do	Do.
Local 23 (skirtmakers)	5	60 days per year	do	$50	do	Do.
Local 25 (blouse and waistmakers)	5	40 days per year	do	$25	Special grant: $25	Do.
Local 32 (corset and brassieres)	5	30 days per year	do	$50	Special grant: $50	Do.
Local 38 (ladies' tailors)	5	31 days per year	do	$50	do	Do.
Local 40 (beltmakers)	5	30 days per year	do	$50	do	Do.
Local 62 (undergarment and negligee)	5	do	do	None	do	6 months union membership.
Local 66 (bonnaz and hand embroiderers)	5	30 days per year	do	$50	None	6 months union membership and in industry.
Local 91 (children's dress, infants' wear workers).	5	45 days per year	do	Up to $50	do	6 months union membership.
Local 98 (rubber and novelty workers)	5	21 days per year	do	$50	do	6 months union membership and in industry.
Local 99 (clerks)	5	60 days per year	do	$50	Special grant: $50	Union membership.
Local 102 (cloak and dress drivers)	5	do	do	$50	None	6 months union membership and in industry.
Local 105 (snow suits and infants' wear workers).	5	30 days per year	do	$50	Special grant: $50	Do.
Local 124 (theatrical costume workers)	5	do	do	None	do	Do.
Local 132 (button makers)	5	do	do	$50	None	Do.
Local 142 (artificial flower division)	5	21 days per year	do	None	do	Do.
Local 142 (shoulder pad division)	5	do	do	do	do	Do.
Local 155 (knitgoods workers)	5	do	do	$50	Special grant: $25	6 months union membership.
Local 177 (alteration workers)	6	31 days per year	$40	$200	None	6 months union membership and in industry.

[1] Surgical benefits in maternity cases vary with the nature of the operation. Typical policies provide $25 for miscarriage, $50 for normal delivery, and $100 for Caesarean section and delivery.

[2] 1 month waiting period for hospitalization if new employee, immediately prior to present employment, did not work in a covered shop; otherwise no waiting period for hospitalization. "In industry" means employment by a contributing employer or availability for employment.

Source: State of New York Department of Labor, Division of Research and Statistics: *Union and Union-Management Administered Health Insurance Plans in New York State, January 1951* (*Publication No. B-44*). New York City, The Department, April 1951, pp. 26–31, and unpublished data, welfare and health benefits department, International Ladies' Garment Workers' Union.

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The New York Hotel Trades Council and Hotel Association Health Center, Inc.*

501 West 50th Street
New York 19, N. Y.

This is a group medical practice plan established in 1950 to provide comprehensive medical care at the health center and the hospital for approximately 35,000 members of the New York Hotel Trades Council (AFL). All costs are paid from an industry-wide health and welfare fund. In 1952, the average cost per eligible person per year was $16.90.

The first industrywide group insurance program for hotel employees was established in March 1945, through the joint action of the New York Hotel Trades Council and the Hotel Association of New York City, Inc. In 1950, with the establishment of the health center, medical services were made available as a part of the industry's insurance program. A special act authorizing establishment of a corporation in the name of The New York Hotel Trades Council and Hotel Association Health Center, Inc., had been passed by the New York State Legislature in April 1949. (See exhibit A for enabling legislation.) Written approval of the health center was given by the New York State Board of Social Welfare in the fall of 1950.

Basic objectives outlined by plan

To promote welfare of New York hotel employees, add to the stabilization of the industry, and contribute to the enrichment of the community. The three main functions of the health center are: (1) to prevent sickness, (2) to find out what is wrong when sickness occurs, and (3) to cure sickness.

Eligibility

Employment by a contributing employer and membership in the New York Hotel Trades Council are requisite for eligibility. All

*Jay Rubin, President, Health Center, and Chairman, Insurance Fund; Charles Rogers, Chairman, Board of Directors of Health Center, and Chairman, Advisory Committee of Insurance Fund; Frank P. Guidotti, M. D., Medical Director, Health Center; William H. Spahn, Administrative Director, Health Center, and Director, Insurance Fund.

employees are eligible for outpatient services at center as of the first day of employment, and for inhospital care after 6 consecutive months in good standing as a member of the council and 4 months of employment in a union-contract hotel or concession which is contributing to the insurance fund.

Benefits terminate as follows: Twenty-eight days after cessation of full or part-time employment by a contributing hotel unless member is disabled, is employed by another contributor within the 28-day period, or his condition is such that the medical director approves continuation of care.

Membership

Approximately 35,000 members of 10 local unions employed in 180 New York City hotels and 52 concessions are covered by the plan. Members range in age from 18 to 85 (median age, 47); 62 percent are males.

Membership represents over 200 occupations; principal employment is as follows:

Maids	6,775	Dishwashers	1,298
Waiters and waitresses	4,087	Telephone operators	1,271
Elevator operators	2,690	Bellmen	1,197
Housemen	1,655	Bartenders	948
Cooks	1,524	Busboys	878

Average annual membership:

1951	33,868
1952	34,762

Methods of financing and cost of care

Methods of financing.—Contributing employers pay 3 percent of their weekly payroll into an insurance trust fund which was jointly established by the Hotel Association of New York City and the New York Hotel Trades Council. Payment covers all welfare benefits, including purchase, renovation, and maintenance of the health center.

The total investment in the health center has been met by transfers from the insurance fund of approximately $850,000.

Item:	*Amount*
Total investment	$842,215
Land and buildings	648,236
Equipment	126,630
Preopening expenses	67,549

Operating costs.—Funds for operating expenses are transferred from the insurance fund to the account of the health center in the amount of approximately $50,000 per month, or $600,000 per year. Operating expenses include the cost of depreciation of the building and equipment and housekeeping and administrative services, as well as professional care. In the 28 months from the program's inception in October 1950, operating costs totaled $1.4 million. Operating costs

for the year ending February 1953 were $588,000 including all indirect costs and $28,000 for depreciation. A summary of operating costs follows. More detailed analysis of operating costs for the year March 1, 1952 to February 28, 1953, is found in table 1.

Item	Amount	Percent
Total operating costs	$588,143	100.0
Medical and surgical care at center	409,438	69.6
Medical and surgical care outside center	68,488	11.6
Ancillary service	106,626	18.1
Pharmacy operation (net cost)	3,590	.6

Allocation of costs to operating departments.—The direct costs of center operation totaled a little more than half of all operating expenses. Direct costs include payments to physicians, salaries and expenses of all the ancillary service personnel, and costs of medical supplies and equipment. Indirect charges represent expenses of the service departments and depreciation of the building and general equipment. These are allocated to the operating departments at the close of each accounting period. The basis for allocation of indirect costs is as follows: Administrative and general expenses are allocated according to salaries, wages and doctors' fees within each operating department; all other indirect expenses are charged to operating departments according to the percentage of floor area which they occupy.

Distribution of indirect costs to the various departments for the year ending February 28, 1953:

	Percent
Medical and surgical	66.66
X-ray	13.61
Laboratory	2.68
Physiotherapy	13.00
Pharmacy	4.05

Table 1 shows the direct and indirect charges for the major types of service for the year ending February 28, 1953.

Average cost per member.—During the fiscal year March 1, 1952, to February 28, 1953, the average cost per eligible member for all services was $16.90, compared with $18.10 during the first full fiscal year of operation. In both periods, nearly 90 percent of the cost was for services given at the center. Costs include administrative expenses and depreciation of the building and equipment.

	Average annual cost per member	
	Mar. 1, 1951–Feb. 29, 1952	Mar. 1, 1952–Feb. 28, 1953
Total services	18.10	$16.90
At health center	16.10	14.90
Outside health center	2.00	2.00

Average cost per service.—Each medical or surgical visit to the center during the fiscal year ending February 28, 1953, cost an average $6.25, of which 52 percent represented direct costs. More than a third of the total costs were physicians' fees.

Total cost per visit	$6.25
Direct expenses:	
Doctors' fees	2.24
General nursing	.67
Other direct expenses	.37
Indirect expenses	2.97

X-ray services cost, on the average, $4.25 during the year ending February 28, 1953. About 60 percent of the costs were for direct expenses.

Total cost per X-ray service	$4.25
Direct expenses:	
Salaries	.91
Doctors' fees	.54
Film	.53
Other direct expenses	.59
Indirect expenses	1.68

Laboratory procedures performed at the center during the fiscal year 1953 cost about $1.20. Salaries of technicians accounted for 43 percent of the total cost.

Total cost per laboratory procedure	$1.20
Direct expenses:	
Salaries	.52
Doctors' fees	.09
Other direct expenses	.15
Indirect expenses	.44

The average cost per physiotherapy service was $1.79 during the fiscal year 1953. Indirect expenses comprised 56 percent of total cost.

Total cost per physiotherapy service	$1.79
Direct expenses:	
Salaries	.50
Doctors' fees	.14
Other direct expenses	.15
Indirect expenses	1.00

After adjustment for pharmacy revenue from sales, each prescription cost an average of $0.15. This includes direct and indirect costs.

Payments to physicians.—Remuneration is on an hourly basis for services at the center, with fees ranging from $6 to $20 per hour. For inhospital medical and surgical services authorized by the center, pay-

ment is made to center physicians in accordance with a fee schedule equivalent to remuneration of physicians under the Blue Shield plan.

During the year ending February 28, 1953, the 175 physicians received payments of $157,000 for services at the health center and $67,000 for services outside the center. Physician payments, summarized below, are shown in more detail in table 2.

Item:	*Payments to physicians Mar. 1, 1952–Feb. 28, 1953*
Total payments	$223,638
Health center, total	156,642
General medicine	53,260
Special medicine and surgery	92,372
Ancillary	11,010
Services outside health center	66,936

SERVICES PROVIDED

Preventive and comprehensive medical care services are provided at the health center and hospital. Appointments are handled at centralized appointment desk except for ancillary services which are handled by the specific departments.

General medical and specialist care.—Services include periodic physical examinations and general and specialist care in 17 clinics. On his first visit to the center the patient is assigned to a particular physician but may ask to be reassigned; a close doctor-patient relationship is encouraged. Each general medical clinic is supervised by an internist, who serves as a consultant to the general practitioner. Referrals to specialty clinics are made upon their joint agreement. After diagnosis is completed the patient is referred back to the general medical clinic.

Ancillary service.—Standard laboratory and other diagnostic procedures, including X-ray and refractions. Therapeutic services include physical therapy, rehabilitation, superficial X-ray therapy, and injection therapy.

Cooperative services.—Information available at the clinic is furnished to the family physician upon request of the physician and the patient. The health center program is integrated with the general insurance program so that a large part of the medical evidence upon which claims are paid originates at the center.

Other services.—Social services by medical-social workers at the center; visiting nurse services; ambulance transportation; drug prescriptions at cost; glasses at reduced rates; distribution of health education material; and preplacement examinations for employees new to the industry if requested by the hotel management.

Further details on the services provided are presented in exhibit B.

Services not provided.—Care for occupational diseases and injuries covered by workmen's compensation law; treatment of service-con-

nected disabilities of veterans; care of conditions requiring highly specialized treatment or confinement to special institutions, such as acute alcoholism, drug addiction, tuberculosis, and mental or nervous disorders; home care except in emergencies to determine need for hospitalization; private duty nursing; and surgery or electrolysis for cosmetic reason.

Facilities

The center has purchased and occupies a five-story building in mid-Manhattan. The building has been renovated and equipped with modern facilities. The first floor contains admitting, registration, and appointment rooms, laboratory, a photofluorographic machine, the pharmacy, and the medical social service departments. Second, third, and fourth floors contain medical clinics; the fifth floor is used for administrative offices.

The center is open 9 a. m. to 6 p. m., on Mondays through Fridays.

Staff

Administrative staff.—The staff consists of an administrative director and 35 other persons engaged in various administrative activities.

Professional staff.—A medical director and 175 physicians (30 general practitioners, 145 specialists comprise the staff). Of this group, 17 general practitioners (averaging 10 hours a week) and 57 specialists (averaging 3 hours a week) participate in active clinic assignments.

Other professional and ancillary personnel include: nurses, 13; laboratory technicians, 4; X-ray technicians, 3; physiotherapists, 2; pharmacists, 2; registered medical librarians, 2; registered medical social service worker, 1; and registered optometrist, 1.

Qualifications for physicians.—Applications from physicians desiring to serve on the staff are reviewed and passed upon by the medical director, the director of medicine or the director of surgery, and the committee on professional standards of the medical advisory council; final aproval is given by the medical advisory council.

Each physician is required to have the following general qualifications: graduate of medical school approved by council on medical education and hospitals of the American Medical Association; one term of internship in a hospital approved by same council or the equivalent in military service; license to practice in New York State; registration with the New York State Department of Education; member in good standing of his county medical society; minimum of $25,000 to $75,000 malpractice insurance; proof of good moral character. In addition, general practitioners must have a staff appointment at an in- or out-patient department of a hospital approved by Joint Commission on Accreditation of Hospitals.

Specialists are required to have certification by the Examining Boards in their respective specialty or appointment as an attending or associate attending physician in a hospital approved by the American Medical Association council on medical education and hospitals for training in specialty.

Utilization of services

Persons receiving care.—During the first 24 months of operation (October 1950–52), 14,936 different persons, constituting 44 percent of the membership, used the health center. During the calendar years 1951 and 1952, 29 percent and 32 percent respectively, of the eligible membership visited the center. Of the 9,804 persons visiting the center in 1951, 86 percent made their first visit. It was also the first visit for 48 percent of the 11,102 different persons visiting the center in 1952.

	1951	1952
Number of different patients visiting the center	9,804	11,102
Number of patients who had not visited center before	8,387	5,310

Tables 3 and 4 show a distribution of persons served in each clinic and indicate whether these patients were new to the health center, new to the clinic, or making a revisit to the same clinic.

During 9 months in 1952 (the only period for which such data are available), 66 percent of the patients were male, as compared with 62 percent in the total membership. A high proportion of the patients were in the older age groups; 48 percent of the center patients were 50 or over.

Item	Percent	
	Patients	Membership
Distribution by age:		
Total	100.00	100.00
Under 20	.28	.15
20–29	9.14	6.86
30–39	17.29	14.64
40–49	25.37	24.01
50–59	28.47	23.73
60–69	16.41	11.95
70 and over	2.89	1.85
Age unknown	0.15	16.81
Distribution by sex:		
Total	100.00	100.00
Male	65.96	61.79
Female	34.04	38.21

Total service provided.—The 11,102 persons visiting the health center during 1952 had 152,839 services, nearly 14 services per patient or 11.5 services per patient if pharmacy prescriptions are excluded.

Visits to the medical clinic represented 43 percent of all services and totaled 1,899 per 1,000 eligibles. Diagnostic procedures, including diagnostic X-ray services, amounted to 1,037 per 1,000 eligibles. Ancillary therapeutic services totaled 602 per 1,000 eligibles.

The number of visits to each clinic and the ancillary services given at the center, summarized below, are shown in detail in table 5.

Item	Number of services		Average per 1,000 eligible members	
	1951	1952	1951	1952
Clinic visits	63,354	65,999	1870.6	1898.6
Diagnostic procedures	47,470	36,030	1401.6	1036.5
Ancillary therapeutic services	21,516	20,915	635.3	601.7
Medical social service visits	4,989	4,181	147.3	120.3
Pharmacy prescriptions	27,809	25,714	821.1	739.7

Center physicians attended 677 hospital cases during the year 1952, or about 19 cases per 1,000 eligible persons. The small number of obstetrical cases reflects the exclusion of dependents from medical care coverage. Other services provided outside the center included primarily calls to determine the need for hospitalization.

Summary of services provided outside health center for calendar years 1951 and 1952:

Item	Number of services	
	1951	1952
Hospital admissions, total	662	677
Surgical	481	461
Medical	181	202
Obstetrical	0	14
Average number of days in hospital	9.83	[1] 9.63
Emergency calls to determine need for hospitalization	383	[2] 400
Consultations outside health center	67	99
Deep X-ray therapy treatments	158	53

[1] Of this number, 9 cases were still in hospital at end of year.
[2] Of this number, 91 or 23 percent were hospitalized.

Services provided by medical department.—General medicine was the department most frequently visited, and allergy, the specialty most frequently used. Although only 504 persons visited the allergy clinic, they had an average of 14.5 services each and accounted for 11 percent of all clinic visits. More different persons visited the eye clinic than any other specialty, with an average of 1.65 visits each. Table 6 shows for each clinic the number of different patients served and the number of visits each patient made.

Diagnoses.—The number of diagnoses, during calendar year ending December 31, 1952, was 20,980, an average of 1.9 diagnoses per patient. Refractive error was the most common diagnosis during 1952, accounting for 7 percent of all diagnoses. Obesity (other than of endo-

crine origin) and varicose veins each represented 3 percent of all diagnoses. A distribution of the most frequent diagnoses is shown in table 7.

Administration

The health center is under the general supervision of the New York State Department of Social Welfare. The center is incorporated, and the authority for conducting all affairs is invested in a board of directors with 20 members (10 from the New York Hotel Trades Council, 10 from the Hotel Association of New York City, Inc., and the impartial chairman of industry). Other groups and individuals participate in administration as follows:

Medical advisory council: Composed of 17 outstanding physicians, including several with experience in industrial medicine and public health, the council was formed while the center was being planned to develop standards and rules regulating professional and technical services. It has a small executive committee and several working committees concerned with professional standards, records, statistics and costs, public relations, preventive medicine, and health education. A joint conference committee maintains liaison with the board of directors. The entire council meets five times a year; its executive committee meets monthly, except for July and August.

Medical board: Composed of the medical director and the chiefs of the various medical departments, the board supervises activities of the professional staff.

Medical director: This officer directs and supervises medical and professional services, reports quarterly to the board of directors, serves as secretary of the medical board, and is a member of the medical advisory council. In cooperation with the administrative director, he coordinates the entire health center organization.

Administrative director: He is responsible for insurance fund, supervising the lay personnel of the health center, directing all business activities, reporting quarterly to the board of directors and serving as an ex officio member of the medical advisory council.

Various evaluations

The findings of a survey made by the Department of Social Welfare of New York State were published in March 1952. The survey group commented favorably on the extent to which the board of directors relied on the medical advisory board for assistance in maintaining a high standard of medical care. Their report pointed out, "It would appear that excellent medical care is available to those who are eligible to attend this health center, as physicians are carefully selected and each medical department is headed by a qualified specialist." In conclusion, the report stated: "The New York Hotel Trades Council and Hotel Association Health Center, Inc., has made a very real con-

tribution to the community's health in making this facility available to employees in the hotel industry in New York City."

Exhibit C contains the full report of survey by the Department of Social Welfare.

The center was certified by the American Foundation of Occupational Health and by the Industrial Medical Association in August 1952.

Other health and welfare benefits

Other insurance benefits are provided through the same insurance trust fund, jointly established by the Hotel Association of New York City, Inc. and the New York Hotel Trades Council, which supports the health center program.

Hospitalization.—Through Associated Hospital Service of New York (Blue Cross); covers members and dependents; provides semiprivate room without cost up to 21 days for each illness and 50 percent of cost for additional 180 days; includes maternity care. During the 8 years in which hospitalization has been provided, 32,777 claims were paid through the insurance fund at an estimated total of $4,183,076.

Life insurance.—One thousand dollars; during the first 8 years the program was in existence (through February 1953), 1,641 claims were paid and $1,636,446 disbursed.

Accidental death and dismemberment.—One thousand dollars; during first 8 years, 92 claims were paid and $85,000 disbursed.

Sickness and accident insurance.—Fifteen dollars a week; during first 8 years, 23,980 claims paid for a total of $1,926,278.

Exhibit A.—*Special enabling legislation passed by the New York State Legislature; became law April 13, 1949 (ch. 585), New York Hotel Trades Council and Hotel Association Health Center, Inc.*

1. Edward P. Mulrooney, Martin Sweeney, Fred O. Cosgrove, Frank L. Andrews, Jay Rubin, Peter A. Moroney, and Peter Crescenti, all being of full age, citizens of the United States and residents of the State of New York, are hereby constituted a body corporate in perpetuity, by the name The New York Hotel Trades Council and Hotel Association Health Center, Inc., as a membership, nonstock corporation to be operated exclusively for the objects and purposes hereinafter set forth.

2. The objects and purposes of the corporation shall be: To establish and maintain a health center to furnish any or all of the following: medical care, surgical care, optical and dental examinations, medical diagnosis, medical advice and treatment, medicine and apparatus, and other health services to ambulatory patients, all through duly licensed physicians, or in the case of optical examinations, through duly licensed optometrists. The corporation shall furnish such care, treatment, services, and supplies only to employees covered by collective bargaining agreements between the New York Hotel Trades Council (a labor organization affiliated with the American Federation of Labor), the Hotel Association of New York City, Inc. (a membership corporation composed of

hotels in the city of New York) and such hotels, either gratuitously or for a compensation determined without reference to the value thereof. Such health center shall not be established and maintained in the state of New York without the prior written approval of the State board of social welfare as to the adequacy of the facilities and standards of care of the health center, including adequacy of personnel, and such health center when established shall be subject to the supervision, visitation and inspection of the State board of social welfare. No part of the activities of the corporation shall be carrying on propaganda or otherwise attempting to influence legislation.

3. The corporation hereby formed shall possess all the powers which by the general corporation law are conferred upon corporations and in addition thereto shall have all the powers and be subject to the restrictions which now or hereafter pertain by law to a membership corporation created by special law so far as the same are applicable thereto and not inconsistent with the provisions of this act.

4. The territory in which the operations of the corporation shall be principally conducted is New York City.

5. The principal office of the corporation shall be located in the county and city of New York.

6. The persons named in the first section of this act shall constitute the first board of directors and the first members of the corporation. They, or a majority of them, shall hold a meeting and elect officers and adopt bylaws. The bylaws may, among other things, prescribe the number, qualifications and functions of the corporation's members and the manner of their selection; the number and qualifications of directors who shall manage the affairs of this corporation, provided that the corporation always shall have not less than seven directors, of whom at least one shall at all times be a resident of the State of New York; the manner in which vacancies among the members, directors and officers, however caused, shall be filled; the method of amending its bylaws; and any other provisions for the management of the affairs of the corporation. The bylaws may provide for the appointment by the board of an executive committee of the board and shall define the powers of such executive committee.

7. This corporation is not organized or created, and shall not be maintained, or operated, for private gain or personal or pecuniary profit or benefit. The income and the property of the corporation from whatever source derived shall be applied solely toward the promotion of the objects of the corporation as above set forth; and no portion thereof or of the net income or earnings of the corporation shall be paid or transferred to or inure to the profit or benefit of any member, officer, director, or employee of the corporation or any private individual provided that nothing herein contained shall prevent the payment in good faith of reasonable and proper remuneration to any member, officer, director or employee of the corporation or to any other person for any service actually rendered to the corporation or the payment of interest on money borrowed.

8. The funds of the corporation shall be derived from one or more of the following sources: funds furnished by employers through The New York Hotel Trades Council and Hotel Association Insurance Fund which is organized and operates under an agreement and declaration of trust, dated as of August 1944, as amended on July 1, 1948; payment made to the corporation by employees covered by collective-bargaining agreements mentioned in section 2 of this act for care, treatment, services and supplies furnished them by the corporation, the amounts of said payments in no event to exceed the cost to the corporation.

9. This act shall take effect immediately.

Exhibit B.—*Summary of medical services provided, New York Hotel Trades Council and Hotel Association Health Center, Inc.*

Physical examination: Routine during first visit to center (including chest X-ray and usual laboratory tests), periodic (members encouraged to receive physicals annually), preplacement for new employees if requested by hotel managements. Beginning in January 1953, letters sent out to all eligibles who have not been at center during year.

Specialist services: Allergy, dermatology, ear, nose, and throat, eye, urology, orthopedics, cardiology, chest diseases, gastroenterology, neurology, psychiatry, obstetrics and gynecology, peripheral vascular, proctology, social hygiene, surgery consultations, minor surgery. Provided in 17 clinics.

Medical and surgical services in hospital: By physicians from center. Center maintains round-the-clock telephone service for emergency cases requiring hospitalization. Ambulance service also provided. Visiting nurse service for post-hospital care when recommended by physician. Hospitalization available to eligible members through Associated Hospital Service of New York.

Optical service: Preliminary examination at center by ophthalmologist, with referral to center's optician if a refraction is required. Outside optical company fills prescriptions at reduced rates.

Pharmacy: Fills prescriptions at cost; maximum charge of $2 for a single prescription.

Health education: Includes nutrition program and publication of material regarding health center activities and other health subjects in union and hotel publications.

Social service: Medical social worker at center plans for hospitalization for patients, offers counsel and advice on environmental, economic and emotional factors related to health needs of patients, consults with medical staff regarding patient's health problems, advises patient on community resources and makes contacts with agencies if patient desires.

Source: Guidotti, Frank P., M. D., *First Medical Care Program in the Hotel Industry,* paper delivered at American Public Health Association annual meeting, October 1952.

Exhibit C.—*Findings and recommendations of the Department of Social Welfare of New York State on The New York Hotel Trades Council and Hotel Association Health Center, Inc., March 12, 1952*

Administration: We are pleased to learn that the board of directors had provided for an objective study of the quality of care afforded by the health center, at the end of its first year of operation, and we found that several recommendations resulting from this study were in the process of being carried out at the time of our visit. We were also interested in the extent to which the board of directors has used the medical advisory board in its endeavor to develop a high standard of medical care. It is apparent that there is a capable administration of the health center in both its professional and its business aspects. Each department is supervised by a qualified director or supervisor and appears to be smoothly coordinated in the total program.

Care of Patients: It would appear that excellent medical care is available to those who are eligible to attend this health center, as physicians are carefully selected and each medical department is headed by a qualified specialist. Except for emergencies, all patients are seen on a definite appointment basis, and sufficient medical time is available to each patient. There is liberal use of consultative services, and well-equipped special departments provide the diagnostic and therapeutic services recommended by the medical staff. Since the entire program

of medical care appears to be under constant evaluation by the medical director, the medical advisory board, and the medical staff organization of the center, it seems that while methods and procedures may change from time to time, a consistently high standard of care will be maintained. The one real problem with respect to patient care is the fact that a patient who loses his employment becomes ineligible for care at the health center after a short period. We are pleased to learn that on recommendation of the medical staff, treatment may be continued to individual cases, and that in other cases, a social worker endeavors to work out an acceptable plan with the patient who must seek care through another medical institution.

The staff of registered professional nurses appears to be adequate to the needs of the health center. It is recommended that a central supply room be set up in the nursing department for the purpose of caring for nursing supplies and equipment.

Although we have mentioned specifically only two professional groups having direct contact with patient, we noted that technical staff in the ancillary departments were qualified in their various fields. It was our observation also that the clerical staff, while not directly related to the patient care program, were making a real contribution to the comfort and ease of patients because of the courteous and pleasant attitude which was displayed at all times.

Plant and equipment: It is evident that the building in which the health center is housed, although not built originally for its present purpose, has been well adapted to that purpose by skillful planning. Great consideration has been given to the privacy, safety and comfort of patients. Cleanliness and order prevail throughout. The New York Hotel Trades Council and Hotel Association Health Center, Inc., has made a very real contribution to the community's health in making this facility available to employees in the hotel industry in New York City.

Source: New York Hotel Trades Council and Hotel Association: *Seventh Annual Report, March 1, 1951, to February 29, 1952.*

Table 1.—*Direct and indirect operating expenses, by type of service, New York Hotel Trades Council and Hotel Association Health Center, Inc., March 1, 1952–Feb. 28, 1953*

Item	Operating expense		
	Direct	Indirect	Total
Professional care, medical and surgical:			
At the health center	$214,662.30	$194,775.73	$409,438.03
Away from the health center	68,487.90	----------	68,487.90
X-ray	29,102.17	18,991.29	48,093.46
Laboratory	22,734.02	9,886.28	32,620.30
Physiotherapy	11,385.71	14,527.64	25,913.35
Total professional care	----------	----------	584,553.04
Pharmacy	----------	----------	3,589.56
Cost of operations	----------	----------	588,142.60
Less sundry income	----------	----------	343.42
Net cost of operations	----------	----------	587,799.18

Summary

Cost of operations before depreciation	$559,530.74	
Depreciation charges	28,268.44	
Net cost of operations, as above		$587,799.18

Source: The New York Hotel Trades Council and Hotel Association Health Center, Inc. May 1953. Unpublished data.

Table 2.—*Payments to physicians, The New York Hotel Trades Council and Hotel Association Health Center, Inc., Mar. 1, 1952–Feb. 28, 1953*

Total payments	$223,638.17
Service at health center:	
Medical and surgical, total	145,632.95
General medicine	53,259.67
Special medicine:	
Allergy	6,909.50
Arthritis and rheumatism [1]	402.50
Cardiology	1,710.03
Chest diseases	1,436.25
Dermatology [2]	5,100.00
Gastroenterology (includes gastroscopies)	2,015.00
Internists	13,547.50
Social hygiene	847.50
Neurology	4,162.50
Psychiatry	1,175.00
Surgery:	
General and minor	3,425.00
Obstetrics and gynecology	5,142.50
Eye	8,182.50
Orthopedics	7,677.50
Ear, nose, and throat	6,417.50
Peripheral vascular	3,040.00
Proctology	2,180.00
Urology (includes cystoscopy)	18,322.50
Chest surgery	115.00
Ancillary services, total	11,009.72
Roentgenologist	6,096.25
Pathologist	2,066.00
Physical medicine	1,997.50
EKG reading, specialties, medicine	849.97
Service outside of health center, total	66,995.50
Medical cases	10,190.00
Surgical cases	48,360.00
Emergency visits	4,765.00
Consultations	1,190.00
Maternity cases	1,275.00
Radio-therapy	335.00
Bronchoscopy	560.00
Electroencephalography	320.00

[1] Clinic title discontinued.
[2] Includes fees for syphilology clinic which was replaced by social hygiene clinic, September 1, 1952.

Source: The New York Hotel Trades Council and Hotel Association Health Center, Inc. May 1953. Unpublished data.

Table 3.—*Total visits to each clinic, by number of first visits and number of revisits, New York Hotel Trade Council and Hotel Association Health Center, Inc., 1951*

Clinic	Total visits	First visit to clinic			Revisits to clinics
		New to health center	Known to health center first visit this year	Previously treated in another clinic this year	
Total	63,354	8,387	1,417	----------	40,339
Admitting	6,362	1,821	103	109	4,329
Allergy	5,616	19	27	324	5,246
Arthritis and rheumatism	611	----------	13	221	377
Cardiology	483	2	12	265	204
Chest disease	472	1	16	293	162
Dermatology and syphilology	3,100	13	90	1,247	1,750
Ear, nose, and throat	4,500	6	105	1,744	2,645
Endocrinology and metabolism	648	----------	8	203	437
Eye	4,072	201	91	2,264	1,516
Gastroenterology	1,029	----------	20	340	669
General medicine and general surgery	22,140	6,315	590	541	14,694
Neurology and psychiatry	522	----------	9	325	188
Obstetrics and gynecology	1,308	1	34	668	605
Orthopedics	2,248	3	61	909	1,275
Peripheral vascular	1,457	1	21	509	926
Procotology	1,618	----------	22	479	1,117
Surgery	1,134	2	21	690	421
Urology	3,966	2	56	724	3,184
Internal medicine [1]	1,392	----------	118	681	593
Physical medicine consultations [2]	676	----------	----------	675	1

[1] Clinic title discontinued June 1, 1951; combined with general medicine.
[2] Started Dec. 1, 1951.

Source: New York Hotel Trades Council and Hotel Association Health Center, Inc., April 1953. Unpublished data.

Table 4.—*Total visit to each clinic, by number of first visits and number of revisits, New York Hotel Trades Council and Hotel Association Health Center, Inc., 1952*

Clinic	Total visits	First visit to clinic			Revisits to clinics
		New to health center	Known to health center first visit this year	Previously treated in another clinic this year	
Total	65,999	5,310	5,792	----------	39,609
Admitting	11,133	2,273	1,870	1,911	5,079
Allergy	7,300	19	197	288	6,796
Arthritis and rheumatism	268	----------	13	79	176
Cardiology	353	1	39	183	130
Chest diseases	472	4	31	291	146
Dermatology	1,018	----------	5	372	641
Dermatology and syphilology [1]	1,727	10	227	560	930
Diabetes [2]	306	----------	32	109	165
Ear, nose, and throat	3,137	34	211	1,372	1,520
Eye	3,698	281	366	1,601	1,450
Gastroenterology (includes gastroscopies)	630	2	59	147	422
General medicine	20,803	2,667	2,062	3,170	12,909
Neurology	481	1	32	268	180
Obstetrics and gynecology	1,619	3	77	647	892
Orthopedics	2,625	7	127	1,004	1,487
Peripheral vascular	1,566	----------	82	386	1,098
Physical medicine consultations	701	----------	33	571	97
Proctology	1,275	1	71	419	784
Psychiatry	139	----------	10	96	33
Social hygiene	400	2	3	235	160
Surgery consultations	603	1	30	340	232
Surgery minor	385	----------	24	304	57
Urology and cystoscopy	5,355	4	191	935	4,225

[1] Syphilology transferred to new social hygiene clinic during year.
[2] Clinic title discontinued during year.

Source: New York Hotel Trades Council and Hotel Association Health Center, Inc., April 1953. Unpublished data.

Table 5.—*Services provided at New York Hotel Trades Council and Hotel Association Health Center, Inc., 1951 and 1952*

Item	Number of services [1]		Average number per 1,000 eligibles	
	1951	1952	1951 [2]	1952 [3]
Clinic visits, total	63,354	65,999	1,870.6	1,898.6
Admitting	6,362	11,133	187.8	320.3
Allergy	5,616	7,300	165.8	210.0
Arthritis [4]	611	268	18.0	7.7
Cardiology	483	353	14.3	10.2
Chest diseases	472	472	13.9	13.6
Dermatology	----	1,018	----	29.3
Dermatology and syphilology [5]	3,100	1,727	91.5	49.7
Diabetes [4]	----	306	----	8.8
Ear, nose, and throat	4,500	3,137	132.9	90.2
Endocrinology and metabolism [4]	648	----	19.1	----
Eye	4,072	3,698	120.2	106.4
Gastroenterology (including gastroscopies)	1,029	630	30.4	18.1
General medicine	22,140	20,808	653.7	598.6
Internal medicine [6]	1,392	----	41.1	----
Neurology	----	481	----	13.8
Neurology and psychology [4]	522	----	15.4	----
Obstetrics and gynecology	1,308	1,619	38.6	46.6
Orthopedics	2,248	2,625	66.4	75.5
Peripheral vascular	1,457	1,566	43.0	45.0
Physical medicine, consultations	676	701	20.0	20.2
Proctology	1,618	1,275	47.8	36.7
Psychiatry	----	139	----	4.0
Social hygiene	----	400	----	11.5
Surgery, consultations	----	603	----	17.3
Surgery, minor	1,134	385	33.5	11.1
Urology (includes cystoscopies)	3,966	5,355	117.1	154.0
Diagnostic procedures, total	47,470	36,030	1,401.6	1,036.5
Audiograms	178	123	5.3	3.5
Basal metabolism	520	411	15.3	11.8
Electrocardiograms	1,669	1,430	49.3	41.1
Eye refractions [7]	74	1,658	2.2	47.7
Laboratory	30,907	21,365	912.6	614.6
Miniature chest X-rays	7,683	4,820	226.9	138.7
Special X-rays	6,439	6,223	190.1	179.0
Ancillary therapeutic services, total	21,516	20,915	635.3	601.7
Physical therapy	12,104	11,538	357.4	331.9
Rehabilitation	2,353	3,160	69.5	90.9
Superficial X-ray therapy	400	233	11.8	6.7
Injection therapy	6,659	5,984	196.6	172.1
Medical social service visits	4,989	4,181	147.3	120.3
Pharmacy prescriptions	27,809	25,714	821.1	739.7

[1] Excludes preplacement examinations given at employers' request: 508 in 1951 and 244 in 1952.
[2] Based on 12-month average eligibles of 33,868.
[3] Based on 12-month average eligibles of 34,762.
[4] Clinic title discontinued during 1952.
[5] Syphilology, transferred to new social hygiene clinic during 1952.
[6] Clinic title discontinued June 1, 1951; combined with general medicine.
[7] First available Dec. 1, 1951.

Source: New York Hotel Trades Council and Hotel Association Health Center, Inc., unpublished data, April 1953.

Table 6.—*Number of patients served and average number of visits made by patients to each clinic, New York Hotel Trades Council and Hotel Association Health Center, Inc., 1951 and 1952*

Clinic	Number of patients served [1]		Average number of visits per patient	
	1951	1952	1951	1952
Admitting	2,033	6,054	3.13	1.84
Allergy	370	504	15.18	14.48
Arthritis and rheumatism [2]	234	92	2.61	2.91
Cardiology	279	223	1.73	1.58
Chest diseases	310	326	1.52	1.44
Dermatology	----------	377	----------	2.70
Dermatology and syphilology [3]	1,350	797	2.30	2.16
Diabetes [2]	----------	141	----------	2.17
Ear, nose, and throat	1,855	1,617	2.43	1.94
Endocrinology and metabolism [2]	211	----------	3.07	----------
Eye	2,556	2,248	1.59	1.65
Gastroenterology	360	208	2.86	3.02
General medicine	7,446	7,899	2.97	2.63
Internal medicine [4]	799	----------	1.74	----------
Neurology	----------	301	----------	1.60
Neurology and psychiatry [2]	334	----------	1.56	----------
Obstetrics and gynecology	703	727	1.86	2.23
Orthopedics	973	1,138	2.31	2.31
Peripheral vascular	531	468	2.74	3.35
Physical medicine, consultations	675	604	1.00	1.16
Proctology	501	491	3.23	2.60
Psychiatry	----------	106	----------	1.31
Social hygiene	----------	240	----------	1.67
Surgery, consultations	----------	371	----------	1.17
Surgery, minor	713	328	1.59	1.17
Urology and cystoscopy	782	1,130	5.07	4.74

[1] Excludes preplacement examinations given at employees' request: 508 in 1951 and 244 in 1952.
[2] Clinic title discontinued during 1952.
[3] Syphilology transferred to new social hygiene clinic during 1952.
[4] Clinic title discontinued June 1, 1951.

Source: New York Hotel Trades Council and Hotel Association Health Center, Inc., April 1953. Unpublished data.

Table 7.—*Most prevalent diagnoses, 100 or more cases, New York Hotel Trades Council and Hotel Association Health Center, Inc., 1952*

Item	*Number of diagnoses*
Refractive errors	1,445
Obesity, not specified as of endocrine origin	728
Varicose veins of lower extremities	722
Essential benign hypertension without mention of heart	513
Hemorrhoids	467
Hay fever	337
Acute nasopharyngitis	332
Acute upper respiratory infection of multiple or unspecified sites	307
Synovitis, bursitis or tenosynovitis without mention of occupational origin	289
Hyperplasia of prostate	281
Inguinal hernia	270
Conjunctivitis and ophthalmia	262
Menopausal symptoms	262
Osteo-arthritis	260
Acute bronchitis	257
Acute tonsilitis	201
Anxiety reaction without mention of somatic symptoms	196
Syphilis, late latent	191
Acute pharyngitis, other	184
Diabetes mellitus	182
Dermatophytosis	178
Anemia of unspecified type	169
Sprains and strains of sacro-iliac region	166
Deflected nasal septum	163
Asthma	159
Iron deficiency anemias	156
Hypertensive heart disease, other and unspecified	148
Prostatitis	146
Flat foot	140
Contusion of trunk	131
Sebaceous glands, other diseases of	125
Cataract	121
Hypertrophy of tonsils and adenoids	115
Chronic nasopharyngitis	112
Uterine fibromyoma	110

Source: New York Hotel Trades Council and Hotel Association Health Center, Inc., April 1953. Unpublished data.

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Correspondence and personal interviews.

Moving Picture Machine Operators' Union of Greater New York, Local 306*

Eligible for medical services through The Health Insurance Plan of Greater New York**

7 East Twelfth Street

New York 3, N. Y.

The Moving Picture Machine Operators' Union, Local 306, AFL, contracts for health and medical services with the Health Insurance Plan of Greater New York. Through 30 medical groups members receive preventive and comprehensive medical care in the home, hospital, and doctor's office; 27 of the groups have medical group centers.

At the end of 1951, after 10½ months of coverage, 3,555 persons (union members and their wives) were eligible for benefits. The full premiums are paid from the local's health and welfare funds secured under collective bargaining agreements. During 1951, the average annual premium paid for each enrollee, covered by the Moving Picture Machine Operators' Union contract, was about $35. In addition, the union members and their wives had hospitalization insurance paid through the local's health and welfare funds.

The Health Insurance Plan of Greater New York is a community-sponsored medical plan established in March 1947. The first contractor was local 89, Chefs, Cooks, Pastry Cooks and Assistants Union, A. F. of L. The largest group of enrollees are employees of the city of New York which includes those of the board of education, board of higher education, the New York City Transit Authority, and all of the other city departments.

Health Insurance Plan provides comprehensive medical services through 30 medical groups and a central panel of physicians with highly specialized skills. Each medical group is made up of a number of physicians, ranging from 20 to 60. The physicians assume joint responsibility for the care of the patients. Each group is equipped to perform all usual diagnostic and therapeutic procedures.

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*Herman Gelber, President, and Ernest Lang, Secretary, Moving Picture Machine Operators' Union of Greater New York, Local 306, 362 West Fiftieth Street, New York 19, N. Y.

**George Baehr, M. D., President and Medical Director, The Health Insurance Plan of Greater New York.

Enrollment in HIP is open to employed groups of 10 or more. With certain exceptions, the employer is required to pay one-half the premium; some employers pay the full premium. Dependents may be covered.

As of April 30, 1953, the Moving Picture Machine Operators' Union (local 306) was one of 19 unions contracting with HIP; the 19 unions had enrolled 53,748 persons out of a total membership in HIP of 391,356. Sixteen of the unions, including the Moving Picture Machine Operators' Union (local 306), paid the entire premium from health and welfare funds secured under collective bargaining agreements. In addition to the union enrollees and the city workers, the plan, in mid-1953, was serving the employees of the United Nations and of over 435 business and industrial firms, private schools, and social welfare agencies.

Eligibility

Labor unions and employed groups may contract with HIP to provide services to their members. In the case of labor unions, 75 percent of the members must be insured, the minimum coverage being 25 persons. The enrolled members of an employed group must constitue 100 percent of a group of 10 persons and 75 percent of a group of 25 or more; if 11 to 24 eligible employees enroll, they must represent at least 90 percent of the eligibles. Dependents, including spouses and unmarried children under 18 who are not in institutions, may or may not be covered, according to the election of the contractor.

There are no age limits for enrollment and any subscriber and his dependents losing their eligibility may continue as subscribers by paying the full premium directly to HIP. Dependents reaching age 18 may enroll as subscribers.

Subscribers must have hospitalization insurance as a requirement for enrollment.

The contract with the Moving Picture Machine Operators' Union (local 306) provides only for coverage of wives. Children may be covered later when the union works out a way of meeting the premium cost for the families.

Membership

The Moving Picture Machine Operators' Union, local 306, contracted with HIP on February 15, 1951. By the end of the calendar year, a total of 3,555 different persons were enrolled through the union welfare fund. Approximately 30 percent of the members and wives were enrolled for the full 10½ months; the others came in at varying times during the year. The total enrollment was equivalent to 2,160 persons enrolled over a full year, as shown in the accompanying table.

Enrollment	Total	10½ months	From 6–10½ months	Less than 6 months
Total	3,555	1,036	1,100	1,419
Annual equivalent	2,160	907	802	451

Wives of the union members were covered and they represented 48 percent of the average annual enrollment.

METHOD OF FINANCING AND COST OF CARE

Method of financing.—Health Insurance Plan was launched with loans totaling more than $850,000 made available by several foundations. These funds were used for preliminary studies, organizational and promotional work, and for pilot operations. As of January 1, 1953, $300,000 of the loans had been repaid.

The operations of the plan are financed from premium payments for persons and families. Employers are required to pay one-half the premium and in some cases pay the full premium; exceptions are made for Federal and State employees and for families in certain cooperative housing projects who pay the entire premium. Unions contracting for coverage of their members may pay 50 percent or more of the premium from health and welfare funds. Under the Moving Picture Machine Operators' Union contract, all of the premium is paid from health and welfare funds.

The base premium rate is paid for a single employee with an annual income up to $5,000 and for families with annual incomes up to $6,500. Premiums are 50 percent higher for individuals and families with incomes above these amounts. The same premium rate is paid for all families of three or more. Annual premium rates are shown in the accompanying table.[1]

Type of contract	Total annual premiums	
	Base rate	Upper-income rate
1 person, no dependents	$34.56	$51.84
Husband and wife or parent and child	69.12	103.68
Employee with 2 or more dependents	103.68	155.52

Premiums are paid into the HIP central office, and HIP pays the medical groups participating in the plan a per capita amount for each enrollee registered. Cash indemnity payments are made by the HIP central office directly to enrolled families living outside the area served by the medical groups. These are comparatively few. This

[1] On July 1, 1953, base rates were changed as follows: 1 person, no dependents—$42.72; husband and wife or parent and child—$85.44; employee with 2 or more dependents—$128.16. No change was made in the upper income rates or in the annual income which determines the upper income bracket.

coverage is provided only as an accommodation to employers and unions with such eligible members.

Payment to the medical groups is not affected by family size since the groups are remunerated on a per capita basis for each member of the family. The rate structure of HIP—a fixed premium per family of 3 or more—combined with the system of per capita payments to the groups requires that the premiums of the one-, two-, and three-person contracts carry the amounts necessary to take care of extra persons in families of 4 or more.

Operating costs.—In April 1953, 81.2 percent of every dollar received by HIP was paid to the medical groups, 4 percent went into a statutory reserve, and 2.6 percent covered other reserves for benefits and working capital. The remaining 12.2 percent included 2.3 percent for medical supervision and health education, another 1 percent for research, and 8.9 percent for the financing of all of the other administrative divisions—such as registrar, comptroller, enrollment, and sales promotion. This overall distribution of the premium dollar does not, however, work out in precisely this way for the individual contracts since these vary in premium return per insured person.

During the 10½ months that the Moving Picture Machine Operator's Union was under contract, the union paid HIP a total of $75,773. In addition to the capitation payments to the medical groups, HIP was liable for cash indemnity payments to the 100 persons (annual equivalent) who lived outside the area served by the medical groups.

Average cost per member.—The average annual premium for each person eligible for care under the union contract was $35.08. This average is made up of an annual equivalent enrollment of 2,095 at the $34.56 base rate and of an annual equivalent enrollment of 65 at the $51.84 upper-income rate.

Payments to physicians.—The participating medical groups are autonomous, and each determines its own system of payments to physicians. The amount paid is based on the physician's rank within the group, special skills, and the proportion of time devoted to HIP work. Most of the participating physicians engage in some non-insurance private practice. Health Insurance Plan has stated that the average net income, from HIP practice, of full-time physicians is equivalent to the reported earnings of non-HIP physicians in New York City. Full time is defined as 40 hours a week for 43 weeks a year. This permits the physician a 4-week vacation, 2 weeks for purposes of education and research and 3 weeks' loss in holidays and sick leave.

Services provided

Comprehensive medical care is available at home, hospital, at the medical group centers, and in doctors' offices. Periodic physical

examination and all kinds of preventive care are included. All types of illness and disability are covered, including preexisting conditions. Services are available 24 hours a day.

General medical and specialist care.—Each subscriber selects one medical group and within that group one general physician as his family or personal doctor. The family physician assumes responsibility for periodic physical examinations and general medical care and arranges for all necessary specialist and laboratory services. Specialties include: Pediatrics; obstetrics-gynecology; general surgery; internal medicine; ophthalmology; ear, nose and throat; orthopedics; dermatology; allergy; urology; neuropsychiatry; radiology; and pathology. Psychiatric diagnosis, but not treatment, is provided. Exceptional procedures such as neurological surgery and congenital heart disease operations are provided by a panel of "super" specialists compensated through a special fund to which all groups contribute.

Ancillary services.—Diagnostic laboratory services of all kinds, X-ray diagnosis and treatment, radium, radon and radioisotope treatment, physical therapy, administration of blood and plasma, eye examinations and prescriptions for glasses.

Other services.—Visiting nurse services in the home and ambulance service which is generally limited to transportation to the hospital.

Services not provided.—Dental care, prescribed drugs and biologicals, eyeglasses, artificial limbs, purely cosmetic surgery, treatments for acute alcoholism, drug addiction, mental and nervous disorders, and conditions requiring institutional care (not in a general hospital), care for workmen's compensation and Veterans' Administration cases, and certain medical services, such as administration of anesthesia in hospitals where HIP medical groups are not permitted to render the service because of hospital regulations.

Facilities

In April 1953, 30 medical groups were affiliated with HIP. Each of the five New York City boroughs and Nassau County had at least one group. Each medical group is required to possess facilities meeting the standards set by the medical control board of HIP. Twenty-seven of the groups have their own group centers or have centers under construction. The remaining three groups which have small enrollments plan to acquire their centers in the near future. HIP estimated that by the end of 1952 over $3 million had been invested in physical facilities and equipment.

All physicians have some office hours at the centers. Family physicians and pediatricians see many of their patients in their own offices, while the specialists do most of their work at the centers.

Staff

Medical staff.—As of the beginning of 1953, 950 general physicians and specialists were associated with the 30 medical groups affiliated with HIP. In a characteristic group of 25 physicians, having a normally constituted family population to care for, there are provided the full-time services of 13 general practitioners, one internist, 2 pediatricians, 2 obstetricians-gynecologists, 2 ear, nose, and throat specialists, 1 surgeon, 1 eye specialist, the half-time services of both an orthopedist and a urologist, and the equivalent time of 2 physicians representing the part-time services in dermatology, neuropsychiatry, radiology, pathology, and other specialties.

Qualifications for physicians.—The professional qualifications of each participating physician are reviewed and approved by the medical control board before he can become a member of a medical group. Every specialist must have a certificate from an American medical specialty board, hold an appointment in his specialty on the staff of a hospital approved by the American Medical Association for resident training, or have equivalent qualifications.

Utilization

The estimated utilization of health and medical services by members of the Moving Picture Machine Operators' Union, local 306, is based on the experience of 679 members and wives who were enrolled in 2 medical groups. These 679 persons constituted 19 percent of the 3,555 persons from the union enrolled in HIP for the 10½ months during which the contract was in effect in 1951. In estimating the utilization patterns for the entire membership, it was assumed that the experience ratios recorded for the study group could be applied to all enrollees. The record of services provided excludes all nonphysician services and the services of pathologists.

Persons receiving care.—Members and wives of the Moving Picture Machine Operators' Union, local 306, were enrolled in HIP for an average of 7 months and 9 days. Of all 3,555 enrollees, regardless of length of coverage under the plan, 57.7 percent (2,052 persons) had visited a physician at least once. Of the one-third enrolled for the full period (10½ months), 70 percent saw at least 1 physician. Nearly 50 percent of those enrolled for less than 6 months had seen a physician by the end of the period. Approximately 500 persons, or about one-seventh of the total membership, received a general physical examination. Table 1 shows, by length of coverage, the number of persons receiving physicians' services.

Total services provided.—The 2,052 persons enrolled for varying lengths of time over the 10½ months who received care made 16,138 visits to physicians, or an average of 7.9 visits per patient. Those enrolled for less than 6 months had, on the average, 5.8 visits per per-

son receiving care, while patients enrolled for the full 10½ months had an average of 9.2 visits.

On an annual basis, the 16,138 physician visits were equal to 7,471 per 1,000 eligibles. After adjustment for length of coverage, those enrolled for 6 months or less visited the physician slightly more frequently than did those enrolled for 10½ months, the annual rates being 7,940 and 7,341 visits per 1,000 eligibles, respectively.

About 91 percent of all physician services received by the union members and their wives were provided at the group centers or in the doctor's office; 4 percent were home visits; and 5 percent, inhospital services. Table 2, summarized as follows, shows for members and wives the number and place of all physicians' services.

Place of visit	Physicians' services	
	Number	Percent
Total	16,138	100.0
Physician's office or group center	14,734	91.3
Patient's home	646	4.0
Hospital	758	4.7

Union members visited a physician more frequently than did their wives. Each 1,000 eligible members had 8,430 physicians' services per year, compared to 6,411 services per 1,000 wives.

Some patients required a large volume of service; the 5.4 percent of patients (110 persons) visiting the physician 20 times or more received 25 percent of all the physicians' services rendered to the union members and their wives. Of the 2,052 different persons visiting a physician at some time during the year (eligible for care for an average of 7 months and 9 days), 18 percent saw a physician once, and 50 percent saw a physician fewer than 5 times. The 50 percent of the patients visiting the physician 4 times or less had 15 percent of all physicians' services. The 44.6 percent who used from 5 to 19 services consumed 60 percent of all services rendered. (See table 3.)

Services provided by medical departments.—Union members and wives received services from at least 13 different types of specialists. Of the total 16,138 services, about 7,300 or 45 percent were rendered by specialists, and the remaining services, by family physicians.

During the year, approximately 2,100 X-ray services were provided by radiologists to the union enrollees. Roughly 64 percent were diagnostic X-ray services, 32 percent deep X-ray therapy, and 4 percent superficial X-ray therapy. On an annual basis each 1,000 eligible members received 989 X-ray services.

Approximately 37 out of every 1,000 enrollees (annual equivalent) were hospitalized during the year. Operations were the cause of the

majority of hospitalizations. On an annual basis there were 24 hospital operations per 1,000 enrollees; members had an annual rate of 19 hospital operations per 1,000, and wives, an annual rate of 28 per 1,000. Minor operations at the office or group medical center were performed at the annual rate of 177 per 1,000 eligibles.

Services provided by ancillary departments.—Data collected by HIP on the number of nonphysician services rendered by each HIP group are not broken down by coverage units. The utilization of physical therapy treatments performed by technicians and of laboratory procedures are therefore not available for the Moving Picture Machine Operators' Union. For all HIP enrollees it is estimated that nearly 1,500 clinical laboratory services were performed for each 1,000 members.

Administration

The board of directors of HIP is composed of 28 persons (with two vacancies on the Board), including the mayor of New York City, officials of the city government, leaders in banking and industry, representatives of labor, and 10 physicians, one of whom is the plan's president and medical director, Dr. George Baehr. Chairman of the board is David M. Heyman.

The medical control board consists of 15 physicians including a representative from the New York Academy of Medicine, 5 from participating medical groups, 2 from the HIP board of directors and its medical department, one from the HIP medical staff and 6 physicians at large. The medical control board determines minimum professional standards for participating medical groups and reviews the professional qualifications of each physician.

A joint conference committee and several subcommittees composed of physicians from the medical groups and of members of the board of directors and staff deals with matters concerning the relationships between HIP and the participating physicians.

The medical department, with the medical control board, is in complete charge of the medical aspects of HIP. The executive vice president, Mr. George Kirstein, is responsible for enrollment procedures and general business management, as well as for all dealings with employers and unions wishing to buy coverage.

Records and research

From the beginning HIP has emphasized the importance of adequate medical records and research. A division of research and statistics constantly studies utilization of services.

Each medical group is required to submit every month a record of the services provided to each patient. The central office prepares monthly and annual analyses of the services rendered in each medical

group. Studies are made of the utilization experience of the total membership and of persons covered under selected contracts, such as the Moving Picture Machine Operators' Union. Studies are also made of the services received by special population groups, such as the aged, young children, and maternity cases.

A special research project scheduled for completion in 1954 will present detailed data on patient's diagnoses and utilization for each of 4 years. Information will also be presented on the services provided to enrollees over the continuous period 1948–51 considered as one unit.

Other health and welfare benefits

Health and welfare benefits are financed through a welfare fund to which employers contribute 7 percent of payrolls. This fund is used to finance the premium payments to the Health Insurance Plan of Greater New York as well as the following benefits.

Hospitalization.—Provided through the Associated Hospital Service of New York (Blue Cross). Members and wives receive hospitalization in a semiprivate room without cost for up to 21 days for each illness and 50 percent of the cost for an additional 180 days.

Sickness insurance.—In addition to payments under the New York State temporary disability law ($30 a week for 13 weeks), members receive $20 for the first 10 weeks of disability and $10 per week for an additional 20 weeks. If the disability lasts longer than 2 weeks, payment is made starting with the first day of disability.

Life insurance.—Four thousand dollars for both active and retired members.

Retirement.—Thirty dollars a week after age 60 and 20 years of union membership; $30 per week after 25 years of union membership regardless of age, if permanently disabled.

Various evaluations

In 1951, HIP received a citation and the Lasker Group Award from the American Public Health Association. Dr. W. S. Shepard, president of the American Public Health Association, and Dr. Ernest Stebbins, chairman of the awards committee of the association, said:

> The American Public Health Association is honored to present a Lasker Group Award to the Health Insurance Plan of Greater New York for its courageous pioneering with a combination of group medical practice and prepayment to provide comprehensive health services. There is no doubt but that these patterns of medical organization and practice have enormous significance for health services of the future.

Subscriber satisfaction with the plan is evidenced by the fact that subscriber terminations in HIP from all causes, including unemployment, removal from the city, change in occupation and dissatisfaction, averaged only 8 percent per year throughout the period 1947–52.

Table 1.—*Utilization of physicians' services, members and wives, Moving Picture Machine Operators' Union, local 306, provided through Health Insurance Plan of Greater New York, Feb. 15, 1951–Dec. 31, 1951*

Item	Total	Length of coverage		
		Exactly 10½ months	From 6 to 10½ months	Less than 6 months
Number of persons enrolled:				
Total enrollment	3,555	1,036	1,100	1,419
Annual equivalent	2,160	907	802	451
Number of persons receiving physicians' services: [1]				
Persons receiving any physicians' services	2,052	722	707	623
Persons who visited radiologist	868	340	293	235
Persons receiving general physical examination	498	173	168	157
Number of physicians' services: [1]				
Total number	16,138	6,658	5,899	3,581
Average annual number per 1,000 eligible	7,471.3	7,340.7	7,355.3	7,940.1
Average number per patient	7.86	9.22	8.34	5.75

[1] Excludes services of pathologist; estimated from experience of 679 members and wives, 19 percent of total enrollment of 3,555.

Source: Health Insurance Plan of Greater New York, Dec. 9, 1952. Unpublished data.

Table 2.—*Number of physicians' services, by place of service, members and wives, Moving Picture Machine Operators' Union, Local 306, provided through Health Insurance Plan of Greater New York, Feb. 15, 1951–Dec. 31, 1951*

Physicians' services [1]	Total	Members	Wives
Number of physicians' services [2]	16,138	9,560	6,578
Physicians' office or group center	14,734	8,757	5,977
Patient's home	646	383	263
Hospital	758	420	338
Annual number of physicians' services [3] per 1,000 eligibles	7,471.3	8,430.3	6,411.3
Physicians' office or group center	6,821.3	7,722.2	5,825.5
Patient's home	299.1	337.7	256.3
Hospital	350.9	370.4	329.4

[1] Excludes services of pathologists.
[2] Estimated from experience of 679 members and wives, 19 percent of total union enrollment of 3,555.
[3] Based on annual equivalent enrollment of 2,160, including 1,134 members and 1,026 wives.

Source: Health Insurance Plan of Greater New York, Dec. 9, 1952. Unpublished data.

Table 3.—*Number of union members and wives receiving specified number of physicians' services, Moving Picture Machine Operators' Union, local 306, through Health Insurance Plan of Greater New York, Feb. 15, 1951–Dec. 31, 1951*

Number of physicians' services received [1]	Persons		Total physicians' services [2]	
	Number	Percent	Number	Percent
Total	2,052	100.0	[3] 14,811	100.0
1	372	18.1	372	2.5
2	283	13.8	566	3.8
3	220	10.7	660	4.5
4	152	7.4	608	4.1
5	141	6.9	705	4.8
6	146	7.1	876	5.9
7	79	3.8	553	3.7
8	89	4.4	712	4.8
9	73	3.6	657	4.4
10–14	241	11.7	2,909	19.6
15–19	146	7.1	2,482	16.8
20–24	47	2.3	1,039	7.0
25 or more	63	3.1	2,672	18.1

[1] Estimated from experience of 679 members and wives, 19 percent of total union enrollment of 3,555.
[2] Excludes services of pathologists.
[3] Excludes an estimated 1,327 services received by union enrollees from other medical groups to which or from which they transferred during 1951.

Source: Health Insurance Plan of Greater New York, Dec. 9, 1952, Unpublished data.

Table 4.—*Number of operations and other hospitalizations, members and wives, Moving Picture Machine Operators' Union, local 306, provided through Health Insurance Plan of Greater New York, Feb. 15, 1951–Dec. 31, 1951*

Item	Total	Male	Female
Number: [1]			
Total hospitalizations	80	33	47
Major operations	29	11	18
Hospitalized minor operations	22	11	11
Other hospitalizations, nonsurgical	29	11	18
Minor operations in office or at center	382	218	164
Annual number per 1,000 eligibles: [2]			
Total hospitalizations	37.0	29.1	45.8
Major operations	13.4	9.7	17.6
Hospitalized minor operations	10.2	9.7	10.6
Other hospitalizations, nonsurgical	13.4	9.7	17.6
Minor operations in office or at center	176.9	192.2	159.8

[1] Estimated from 10½ months experience of 679 members and wives, 19 percent of total enrollment of 3,555.
[2] Based on annual equivalent enrollment of 2,160, including 1,134 members and 1,026 wives.

Source: Health Insurance Plan of Greater New York, Dec. 9, 1952. Unpublished data.

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Correspondence and personal interviews.

Labor Health Institute*

1127 Pine Street

St. Louis, Mo.

This is a group medical practice plan established in 1945 by the St. Louis joint council of the United Retail, Wholesale, and Department Store Employees (CIO) to serve members and dependents of the various locals. In 1947 these locals left the CIO and were independent for 1 year; in 1948 they affiliated with local 688 of the Teamsters, A. F. of L. On June 30, 1952, about 13,700 persons were enrolled at the institute. All were eligible for physician and dental services in the institute, home, and hospital, and almost all were eligible for hospitalization. The costs are paid from health funds obtained through collective bargaining. The average annual cost for full benefits, excluding reserve accumulation, in 1951–52 was about $50 per person eligible for care.

Studies of the health problems of union members, conducted on an industrywide basis, had revealed lack of medical care arising from lack of ability to pay, nonavailability of health services after working hours, and unawareness of the importance of medical care. As a step toward achieving health security for the union members, in 1943 the joint council of the United Retail, Wholesale, and Department Store Employees was instructed to draw up plans for the health care of the members. It was found that most members were employed in shops too small to afford adequate inplant medical facilities. Extensive investigation of the various existing insurance plans showed that these did not provide as complete medical services as the union wanted. The union, therefore, took the initiative in stimulating the interest of employees and employers in developing their own prepayment medical care plan which would provide comprehensive medical services. Health problems were discussed extensively at union meetings, with delegates from the shops, with management representatives, and in union newspapers. After 2 years of planning, the Labor Health In-

*H. J. Gibbons, President, Labor Health Institute, and Secretary-Treasurer, Warehouse and Distribution Workers' Union, Local 688, International Brotherhood of Teamsters; John O. McNeel, M. D., Medical Director.

stitute was established, with Dr. Elmer Richman serving as its first medical director.

Shortly after the Labor Health Institute was organized, its legality was questioned by one of the contributing firms which declared it to be a union-controlled project violating the intentions of the Taft-Hartley Act. However, a court decision, which is presented in exhibit A, upheld the legality of the organization.

Basic principles outlined by the plan

1. *Service plan.*—This is not an insurance program. Coverage is therefore limited to service and does not include cash payments. Service is provided at the medical center, in the home and at the hospital based on need.

2. *Health care.*—This is a functional program designed primarily to prevent illness. All influences on a person's health are taken into account, instead of concentrating solely on the treatment of a specific disease. Care for illness is as comprehensive as practicable.

3. *Sick care.*—The emphasis is on the treatment of the total person rather than a specific disease. Sick care is as comprehensive as practicable.

4. *Group medical practice.*—Physicians, dentists, and surgeons are organized in a systematized group medical practice program working under one roof and in one organization with good medical equipment and facilities.

5. *Budgeting for health.*—The Labor Health Institute finances medical care through funds obtained under collective bargaining.

6. *Democratic control by membership.*—Members govern the Labor Health Institute. Administration and policies rest with the board of trustees.

7. *Standardization of practices and qualified professional supervision.*—Doctors follow the approved standards and ethics of their profession. The Labor Health Institute follows the principles for cooperatives accepted by both professional and lay groups covering voluntary plans.

8. *Community responsibility.*—Because the Labor Health Institute believes that health is both an individual and community problem, it participates in community health activities with both official and voluntary agencies.

Eligibility

Coverage under the Labor Health Institute may be achieved through union membership, as a dependent of a covered union member, or through a cooperative community group. Although any group in the community may participate, less than 2 percent of the membership has joined in this manner. For coverage under union contracts, locals bargain separately with individual employers. Of these, 90

percent (employing 94 percent of the members) have negotiated contracts covering both union members and their dependents. The types of membership are:

Regular members.—1. Union members and their dependents covered by collective bargaining agreements that provide for payments based on 5 percent of payroll; both members and dependents have full coverage.

Dependents include wife or husband and children over 60 days and under 18 years of age; a member with no dependents of this type may select 1 adult dependent (mother, father, sister, brother, or child), 18 years of age or over and living in the same household, provided that such person is wholly dependent on him for support. A typical clause in the collective bargaining agreement providing 5 percent contribution for membership in the Labor Health Institute is given in exhibit B.

2. Union members covered by collective bargaining agreements that provide for payments based on 3½ percent of payroll; no dependent coverage.

Associate members.—Dependents of union members, covered by 3½ percent collective bargaining agreements, for whom the members make small regular payments to enable them to obtain limited special and surgical benefits at reduced fees.

Special members.—1. Individuals who have elected to continue membership after leaving the collective bargaining unit.

2. Members of a small cooperative community group purchasing medical and surgical services only.

3. Dependents of wage earners under 3½-percent contracts for whom only hospital benefits have been purchased.

Persons who belong to a union at the time the contract is signed are eligible for services 30 days after the contract goes into effect; new employees are eligible after 60 days of employment unless transferring from another covered shop.

During sickness and temporary layoffs, eligibility for medical services and hospitalization continues for 60 days plus an additional 30 days for each year of Labor Health Institute membership, up to a maximum of 180 days.

Upon the employee's resignation or dismissal, eligibility as group member terminates automatically; employees rehired within a year after termination are reinstated immediately.

Upon retirement after 1 year of membership, employees remain eligible for services for 60 days from retirement date and for an additional 30 days for each year of membership up to 180 days. Application may be made for special membership within 60 days of retirement; the medical director may reject or condition acceptance upon findings of the physical examination.

Membership

Average annual membership.—Average annual membership including union members, dependents and others:

1949	6,070
1950	9,058
Fiscal year 1951–52	14,606
Medical and hospital care	13,706
Medical care only	497
Hospital care only	403

Financial status of members.—Average monthly income of union members:

1950	$195.00
1951–52	211.00

Size of employee group.—Union members classified according to size of employee group under contract, May 1, 1952:

Number of persons employed	Companies		Union members	
	Number	Percent	Number	Percent
Total	80	100	6,625	100
1–24	40	50	453	7
25–49	16	20	570	9
50–74	5	6	282	4
75–99	3	4	274	4
100–199	8	10	1,140	17
200–499	6	8	2,315	35
500–1,000	2	2	1,591	24

Method of financing and cost of care

Method of financing.—The entire cost for regular members is paid by the employer under collective bargaining agreements. The amount is fixed as a percent of payroll. Associate and special members make regular payments to the Labor Health Institute. Average monthly payments during the fiscal year 1951–52, for each type of membership, were as follows:

Regular members.—1. For union members under collective bargaining agreements in which employer payments are based on 5 percent of payroll—$5.10 for each member and each dependent.

2. For union members under collective bargaining agreements in which employer payments are based on 3½ percent of payroll—$4.89 for each member; no dependents covered.

Associate members.—Dependents of union members covered by 3½-percent collective bargaining agreements, for whom members make regular payments for the privilege of obtaining limited medical and surgical benefits at reduced fees—$0.31.

Special members.—1. Individual members who continue payment of dues after leaving place of employment—$3.53.

2. Members of small community groups—$2.58.

3. Dependents eligible for hospitalization only—$1.35.

Average cost to employer per member.—During the fiscal year 1951–52 the average annual cost to the employer was:

Per eligible person (employees and dependents—5 percent contract)	$61.18
Per employee—5 percent contract	130.05
Per employee—3.5 percent contract	58.68

Operating costs.—Total income of the Labor Health Institute was about $630,000 in 1950 and $875,000 in the fiscal year 1951–52. In both years 97 percent of the income came from membership dues and the remainder largely from medical fees. Expenses for medical and dental care, ancillary services, and administrative and depreciation costs represented 55 percent of the income in 1950 and 64 percent of the income in 1951–52; hospital expenses amounted to 16 percent of the income in 1950, 20 percent in 1951–52. Administrative costs, including depreciation, totalled about 25 percent of the income in 1951–52. Reserves and undivided income declined from 29 percent of income in 1950 to 16 percent in 1951–52.

Summary of income and expenses, Labor Health Institute, 1950 and fiscal year 1951–52:

Item	1950	Fiscal year 1951–52
Income	$631,214	$874,504
Dues	612,142	849,323
All other	19,071	25,181
Operating expenses [1]	446,184	733,203
Medical	346,583	559,543
Hospital	99,601	173,660
Reserves, expansion fund and undivided income	185,030	141,301

[1] Includes administrative costs, and depreciation of building and equipment.

Table 1 contains a more detailed presentation of income and expenditures for the calendar year 1950 and the fiscal year 1951–52.

Average cost of medical and dental services and hospitalization.—The average cost of medical and dental services and hospital care, including administrative expenses but excluding reserves, for all persons eligible for care was about $50 in the fiscal year 1951–52; 80 percent of that cost was for medical and dental services and 20 percent for hospitalization. For each person who received care, medical and dental costs averaged $63, and the average hospital bill was $96. The cost per patient visit in 1950 was $4.94, of which payments to physicians and dentists represented nearly one-half. In the fiscal year 1951–52 the cost per patient visit was $5.42.

Item:	*Average cost, 1951–52*
Medical and dental care:	
Per eligible person	$39.40
Per person receiving care	63.20
Hospitalization:	
Per eligible person	10.44
Per hospital case	95.87

Table 2 shows the average cost of medical and dental services and hospitalization for the years 1949, 1950, and fiscal 1951–52.

Costs per visit by department.—Patient visits to neuropsychiatry were the most costly ($8.81 per visit in 1950); visits to the allergy clinic and radiologist, the least costly.

Average cost per patient visit by specialty at center, home, and hospital, 1950 [1]

All specialties	$4.46	Ear, nose, and throat	$4.69
General medicine	4.35	Orthopedics	4.56
Dermatology	4.16	Urology	5.44
Neuropsychiatry	8.81	Eye	5.43
Allergy	3.77	Radiology	3.46
Pediatrics	4.85	Dentistry	4.67
Gynecology and obstetrics	4.77		

[1] Includes average indirect cost per patient visit, $2.31.

Payments to physicians.—Doctors are paid on the basis of scheduled hours which include vacation, holiday and sick leave time, administrative activities, and staff meetings, as well as actual patient hours at center and hospital. Additional fee-for-service payments are made for office calls, home visits, and for consultations and nonstaff referrals. Physicians making home calls outside the city limits also receive mileage allowance. The methods of compensating physicians are summarized in appendix C and table 3 shows the amount of payment for each type of duty.

Total income and amount paid to physicians in specified years

Year	Total income	Payments to physicians	
		Amount	Percent of total income
1950	$631,214	[1] $165,482	26
1951–1952 fiscal year	874,505	[1] 256,612	29

[1] Figures adjusted to exclude payments applicable to time periods other than the one in which payment was made; therefore, not identical with figures in table 1.

Of the nearly $260,000 paid to physicians in 1951–52, approximately $155,000 was for patient care at the medical center and the hospital, $36,000 for administrative duties, and $21,000 for home care.

Hourly rates for each specialty are based on a study of doctor fees made by the institute. These rates are set at a level that assures that on an annual basis (fifty-two 40-hour weeks) Labor Health Institute physicians receive an income approximately equal to the average received by all independent specialists in the United States.

In addition, a 25-cent-per-medical-center-hour annual increase is provided up to 4 years' service for all specialties except pediatrics, general surgery, and dentistry.

The radiologists received payments which, on an annual basis, guaranteed them the highest average income ($24,129) of the Labor

Health Institute specialists. The ophthalmologists and the neuropsychiatrists also received payments which on a full-time basis were equivalent to over $20,000 annually. Dentists and physicians in internal medicine had the lowest full-time equivalent income.

The payments to Labor Health Institute specialists, on an annual basis, were generally higher than average net incomes of all United States specialists. Table 4 shows for each specialty the total payments to physicians, the amount of payments for all types of scheduled hours, and the average income per full-time equivalent physician.

Services provided

The Labor Health Institute offers preventive services and comprehensive medical care at the center, home, and the hospital. Health education has a special place in the program. Physicians and all other professional personnel on the staff are instructed on its importance. A detailed description of the services provided is contained in exhibit D.

General medical and specialist care.—General medical care is provided by a personal physician (selected by the patient) who is also responsible for periodic physical examinations and for making arrangements for all specialist or ancillary services except dentistry. The institute is served regularly on a part-time basis by physicians in 14 different specialties, including radiology and dentistry. After an initial examination, the patient is assigned to a personal dentist. Dental services are free of charge; drugs and materials are provided at cost.

Ancillary services.—All usual laboratory services, diagnostic and therapeutic X-ray and physiotherapy.

Other medical services.—Hospitalization up to 90 days each year, drugs at the Labor Health Institute pharmacy at special rates; visiting nurse services; and eyeglasses at discount.

Services not provided.—Care for conditions requiring treatment in a sanatorium or public institution.

Care for tuberculosis, mental or nervous disorders, or alcoholism, after diagnosed as such.

Care to patients under treatment by another physician who has not released them.

Blood, blood plasma, or surgical supplies and appliances.

Illegal operations, plastic surgery, and similar nonessentials.

Care for patients who do not follow instructions or refuse treatment.

Care for preexisting chronic conditions of employees hired after the original contract was signed unless the medical director agrees to accept the condition for treatment.

Facilities

The institute owns and occupies a five-story building in the downtown district; up-to-date facilities include two complete X-ray rooms; laboratory equipped for various tests, including urine analysis, blood counts, blood tests, and basal metabolism tests; physiotherapy department equipped with ultraviolet, infrared and diathermy, and other apparatus; drugstore where prescriptions and ordinary drugs are provided at special rates; nine dental chairs and an office equipped with dental X-ray machine.

The center is open from 9 a. m. to 6 p. m. Mondays through Fridays and from 8 : 30 a. m. to 12 noon on Saturdays.

Staff

Administrative staff.—Twenty-four persons, including medical director, chief of medical and surgical service, chief of dental service, and business manager.

Professional staff.—Numbered about 80 during past year. In addition to specialists on the staff, 5 associate physicians in East St. Louis make home and hospital visits and provide care in their own offices.

Staff	July 1, 1952	Apr. 1, 1953	Staff	July 1, 1952	Apr. 1, 1953
General practitioners	10	10	Laboratory technicians	3	3
Specialists	32	30	Dental assistants	4	6
Dentists	8	9	Druggists	2	2
Registered nurses	13	13	Registered medical record librarian and assistants	6	6
X-ray technicians	2	2			

Except for the medical director, all physicians are part-time physicians in private practice in the community; specialists are all diplomates of specialty boards or board qualified.

Physicians' hours.—The number of physicians in each specialty and the day's schedule for each specialty as of July 1, 1952, are shown in table 5. Both general medical care and dentistry are available at nearly all hours that the center is open. Services of radiologists, allergists, and dermatologists are available at the center less than 10 hours a week.

In table 6 the actual number of physicians' hours spent at the center during 1951–52 and the number of hours per 1,000 eligibles for each specialty is shown. In the aggregate, 28,000 physician hours were allocated to the center, including 22,000 hours spent seeing patients. Center patient hours totalled 1,555 per 1,000 eligibles.

Medical center hours account for approximately 80 percent of all physicians' time. Pediatricians, however, devoted 37 percent of their hours to home calls; surgeons, 37 percent of their hours to hospital operations or visits; and obstetricians and gynecologists combined, 47

percent of their hours to hospital deliveries or visits. Table 6 shows a 1951 distribution of physicians' hours by place of service.

Physicians' time per patient visit.—The time physicians devoted to each patient visit at the medical center ranged from 5 minutes for the radiologists' interpretation of the average X-ray to 48 minutes for each visit to the neurosurgeon. Time for services outside the center is estimated as follows: one-half hour per office visit, 1 hour per home call, 10 minutes per day for hospitalized cases under physician care, one-half hour per outpatient visit in hospital, 1 hour per consultation (may include 2 or more visits), 2 hours for major and 45 minutes for minor hospital operations, and 3 hours for delivery.

Number of minutes per patient visit at center, 1951–52:

Internal medicine	17	Ear, nose and throat	10
Pediatrics	11	Eyes	17
Allergy	15	Genitourinary	18
Dermatology	7	Gynecology-obstetrics	14
Neuropsychiatry	30	Orthopedics	12
Neurosurgery	48	X-ray	5
General surgery	12	Dentistry	28

Utilization of services

Persons receiving care.—During the year 1950 and the fiscal year 1951–52, 60 percent and 62 percent, respectively, of the eligible members received medical care; fewer than 1 out of every 100 members was hospitalized.

Total services provided.—The nearly 9,000 persons receiving medical services in 1951–52 had 103,196 visits, or 11.6 visits per person receiving care, and 7,265 visits per 1,000 eligibles. In 1950, 5,400 persons had 70,200 visits during which 119,400 services were given. The count of visits excludes those at which only the nurse gave care; the count of services provided includes nurses' care.

Services provided by medical departments.—In 1951–52 physicians gave 4,544 services per 1,000 eligibles, not counting hospital visits which in 1950 were 603 per 1,000 eligibles.

	1950	1951–52
Persons eligible for medical care	9,058	14,203
Persons receiving medical care	5,393	8,854
Persons eligible for hospitalization	9,959	14,105
Number of hospital cases	688	1,310

Place of visit	Number of visits or services	
	1950	1951–52
Medical center	42,518	58,165
Home	1,851	3,853
Office and non-Labor Health Institute referrals	953	2,523
Hospital	5,464	NA

The department of internal medicine was most frequently visited with the gynecology-obstetrics and ear, nose, and throat departments ranking next. Table 8 (1950) and table 9 (1951–52) show for each department the number of physicians' visits per 1,000 eligibles, by place of service.

On the average, every 1,000 eligible persons made 1,261 visits to the dentist (fiscal year 1951–52); an average of nearly 3 services were given during each visit. In 1950 dental visits amounted to 1,374 per 1,000 eligibles.

	1950	1951–52
Visits	12,449	18,019
Services	36,850	51,493

In table 10, the number of dental services by type of service, per 1,000 eligibles for 1950 and 1951–52, is shown.

Hospital services.—During the fiscal year 1951–1952, 9 persons out of each 1,000 eligibles were hospitalized; hospitalization totaled 638 days per 1,000 persons eligible for hospital care. In 1950 each 1,000 persons eligible for hospital care received 483 days of hospital care and not quite 7 out of every 1,000 persons were hospitalized.

	1950	1951–52
Number of cases	668	1,310
Number of inpatient hospital days	4,813	9,006
Average length of hospital stay	8	7½
Number of deliveries	106	225
Number of hospital operations	335	605

In both years operations and deliveries accounted for nearly two-thirds of all hospital cases. The gynecology-obstetrics department had the greatest number of hospital cases and hospital days. See table 9 for hospital utilization in 1951–52 by department.

Services provided by ancillary departments.—In relation to the number of persons eligible for care, fewer X-ray and laboratory services were provided in 1951–52 than in 1950. During 1951–52, 10,000 X-ray services were given, or 711 services per 1,000 eligibles, as compared to 856 in 1950. The 21,600 laboratory services received in 1951–52 represent 1,521 per 1,000 eligible persons, as compared with 2,025 in 1950.

Type of service	Number of services	
	1950	1951–52
X-ray	7,754	10,095
Laboratory	18,345	21,600
Nurse (center and home)	10,428	NA
Physiotherapy	867	1,010
Other	710	942

Tables 11 and 12 contain a detailed breakdown of the type of X-ray and laboratory procedures given in 1950 and in 1951–52.

Administration

Policy control of the Labor Health Institute is vested in the membership. At the annual membership meeting, held in September each year, broad policies are set for the organization for the coming year. The members are represented in day-to-day interests by the board of trustees, elected annually by the membership. The board meets quarterly to conduct the affairs of the Labor Health Institute. From among the board of trustees is elected an executive committee that meets monthly.

Bylaws of the Labor Health Institute provide that the 27 members of the board shall be broadly representative of the interests of the sponsoring unions, the management under contract, and the general public of St. Louis.

The president, elected by the board of trustees, although a nonpaid officer, supervises and coordinates all nonmedical activities of the Labor Health Institute. At present, he also carries the duties of the business manager, that position being vacant.

The medical staff is under the direction of a full-time medical director, who is selected by the board of trustees and reports regularly to the president of the board of trustees.

Nine standing advisory committees aid the board of trustees throughout the year—the budget, personnel, membership education, voluntary groups, new projects, public relations, rules and regulations, nominating, and medical conference committees.

The medical conference committee serves in an advisory capacity to both the president of the board and the medical director. The committee consists of five members selected from outstanding men in the community representing both private practitioners and full-time teachers in medical and dental fields.

The organizational chart is given in exhibit E, and a description of functions of administrative personnel is presented in exhibit F.

Medical records

A continuous chronological medical record is maintained for each patient. Standard forms are used for physical examinations, laboratory data, X-ray reports and the like. Physicians record each patient visit, whether at center, hospital, home, or office.

A diagnostic file has been set up according to standard nomenclature of disease and operation; diagnoses are cross-indexed. Detailed descriptions of record-keeping procedures and patient control through the use of records are given in exhibit G.

Other health and welfare benefits

In January 1952, local 688 had negotiated agreements, with employers of 2,500 union members, providing for employer-financed retirement, disability and life insurance benefits and a welfare program. In early 1952 most of these agreements were before the Wage Stabilization Board awaiting approval. The agreements provided for: Retirement benefits equal to $30 a month plus $1 a month for each year of union membership, disability benefits equal to $2 a month for each year of union membership with a minimum of $25 per month, life insurance equal to $2,000 for persons under 65 and $500 for those over 65.

Other negotiated programs already in operation were:

Life insurance—1,200 members in 43 firms covered by employer-financed policies: $1,000 policy for persons with less than 5 years of union membership; $2,000 policy for persons with 5 years or more of union membership.

Vacation—In 1951, 92 percent of local's members received at least 2 weeks' paid vacation.

Various evaluations

An evaluation of the program was made in December 1948, at the request of the St. Louis Social Planning Council and the Labor Health Institute, by Henry G. Farish, M. D., specialist in medical audits and hospital consulting, and Franz Goldmann, M. D., associate professor of medical care at the Harvard University School of Public Health. The operation of the Labor Health Institute was reviewed, present and former staff members were interviewed, and consultations were held with various other persons. The appraisal of the quality of service was based on the minimum standards for medical service in industry and the minimum standards of hospitals developed by the American College of Surgeons, with additional criteria developed for use in the evaluation, which included a detailed examination of a large number of medical records (exhibit H).

The study found that "All the physicians, dentists, nurses, and technicians on the regular staff of the Labor Health Institute possess the qualifications and experience necessary for the proper performance of their duties . . . (and that) the services offered to the members of the Labor Health Institute and other patients are broad in scope and readily accessible . . . The amount of service actually received by the persons covered by regular payment plans is such as to place the Labor Health Institute in the top bracket of group-practice prepayment plans and comes close to ideal standards." The study commented favorably on the emphasis placed on the patient-physician relationship and the comprehensive record-keeping system. A detailed summary of the findings is given in exhibit I.

In a survey of members of local 688 whose shops were organized into the union prior to 1943, members were asked, "How does the medical service given by the Labor Health Institute compare to that given by private doctors?" Replies indicate that 25.8 percent of the members thought it better, 42.9 percent said it was about the same, 6.9 said it was not as good, and 24.4 percent, including those not having had experience with the Labor Health Institute, did not respond.

More than three-fourths of the surveyed members think it is very important for the union to sponsor medical service and health aid for its members, and an additional 17 percent think it worthwhile. Workers in the survey shops constituted 72 percent of the total membership of the local in the winter of 1948–49.[1]

Exhibit A.—*Legality of St. Louis Labor Health Institute under Taft-Hartley Act upheld*

A decree issued on June 15, 1948, in the District Court of the United States, for the Eastern Judicial District of Missouri, upheld the legality of the Labor Health Institute. Findings of fact by the court were as follows: "That defendant, St. Louis Labor Health Institute, is an independent corporation and is not a representative of any of the plaintiff's employees within the meaning of section 302 of the Labor Management Relations Act of 1947 . . . that the payments so required to be made by plaintiff to defendant St. Louis Labor Health Institute under the terms of said contract are lawful and are not in violation of Labor Management Relations Act, 1947, and particularly such payments are not in violation of section 302 of said act."

The organizational structure of the institute was said by Mr. H. J. Gibbons, then its president, to be an important consideration in this decision. The organization is a nonprofit corporation under Missouri law, is owned and controlled by its members, and does not represent itself or its members in any collective bargaining negotiations with companies under contract to provide health and medical services.

Source: Cooperative Health Federation of America: Cooperative League News Service (June 29) 1948. Mimeographed.

Exhibit B.—*Typical clause in collective bargaining agreement providing membership in Labor Health Institute, St. Louis*

It is agreed that the company will pay into the St. Louis Labor Health Institute a sum equal to 5 percent of the gross pay (before deductions for social security, taxes, union dues, etc.) of all full-time regular employees of the company within the collective bargaining unit covered by this agreement, plus 5 percent of the pay of any other persons regularly in its employ full time, whom the company wishes to enroll. Said 5 percent payments shall entitle the employees of the company covered by this agreement to regular membership in the St. Louis Labor Health Institute for themselves and their dependents as associate members under the family "A" plan. He and his dependents shall be entitled to such medical services and hospital benefits as are provided in the rules and regulations of the St. Louis Labor Health Institute.

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[1] Rose, Arnold H.: *Union Solidarity, The Internal Cohesion of a Labor Union.* Minneapolis, The University of Minnesota Press, 1952, pp. 91–92.

Payments to the St. Louis Labor Health Institute hereunder shall be made weekly, biweekly, monthly, or otherwise, as may be agreed between the company and the St. Louis Labor Health Institute and shall continue for the duration of this contract.

The company shall have no right, title, or interest in any monies so paid or in the funds of the St. Louis Labor Health Institute, or its control or management except as provided in the bylaws of the St. Louis Labor Health Institute. No employee shall have any right, title, or interest in the control and management of said St. Louis Labor Health Institute, except as provided in the bylaws of the St. Louis Labor Health Institute.

The company's and employees' right, title, and interest shall be limited to medical and health services to employees and members of their families while said employee is in the employ of said employer except as otherwise provided by the bylaws of the St. Louis Labor Health Institute.

Source: St. Louis Labor Health Institute: *Annual Report, 1950.* Mimeographed.

Exhibit C.—*Proposed method of compensating physicians, Labor Health Institute, St. Louis*

GENERAL ARRANGEMENTS

Conditions of employment that generally apply to all regular Labor Health Institute staff doctors are known as "general arrangements." They are as follows:

1. *Compensation for home calls*

(*a*) Day calls, $5.

(*b*) Night calls after 8 p. m., $7.50.

(*c*) Night calls after 12 midnight, $10.

(*d*) Territory:

The above standard fees apply to a territory bounded in the south by Loughborough Avenue; in the west by North and South Road and in the north by West Florissant Boulevard. Beyond this territory an additional compensation of $1 per every 2 miles will be paid one way.

(*e*) In the event two or more patients of same family are seen on the same visit, the charge for the subsequent patient care is one-half of the amounts listed above.

2. *Compensation for office visits*—For patients referred to the physician's, surgeon's and dentist's private office on authorization of the medical director, a fee of $3 and up will be paid at the discretion of the medical director.

3. *Nonroutine hospital visits*—For nonroutine hospital visits made where physicians hold no appointment or to institutions, such as convalescent homes, etc., physicians, surgeons and dentists will receive the same compensation as for home calls provided that these visits are authorized by the medical director.

4. *Outpatient hospital calls.*—Physicians, surgeons, and dentists will receive same rate as for home calls. Cases seen at hospital by agreement between patient and physician should be indicated as outpatient calls.

5. *Consultations.*—Consultations authorized by the medical director will be paid at the rate of $10 per consultation for dentists, physicians, and surgical specialists with the exception of neuropsychiatrists, who will be paid at the rate of $15 per consultation. Consultation shall be defined as—when a patient is seen at the request of another physician, surgeon or dentist while that patient is hospitalized by the physician requesting the consultation.

6. *Vacations.*—Two weeks after completing 1 year's service, 3 weeks after completing 2 years' service. Vacation time is computed on the basis of the number of hours assigned to the physician, surgeon, or dentist per week. Vacations

are not to accumulate from year to year. The medical director will reserve the right to schedule the vacations of the physicians and dentists at the convenience of the institute.

7. *Sick leave.*—Two weeks after 1 year's service, 3 weeks after completing 2 years' service. Sick leave time is computed on the basis of the number of hours assigned to the physician, surgeon, or dentist per week. The medical director reserves the right to require proof of illness before sick leave is granted.

8. *Holidays.*—New Year's Day, Christmas Day, Decoration Day, Fourth of July, Labor Day, Armistice Day, Thanksgiving Day. In the event any physician, surgeon, or dentist is scheduled on any of the above holidays, he will be compensated at his regular hourly rate.

9. *Severance Pay.*—Severance pay will be payable only in the case of discharge or layoffs. Two weeks after completing 1 year of service up to a maximum of 6 weeks.

10. *Leave of absence.*—No pay will be granted for leave of absence. All absenteeism shall be deducted unless authorized by the medical director.

11. *Hours scheduled for hospital service, home service, and referred service.*—These hours will be determined by the medical director or his representative. The institute will guarantee scheduled hours on a monthly basis and the medical director shall give notification 30 days in advance if he desires to change assigned scheduled hours.

12. *Social security and withholding tax.*—Taxes will be deducted on a monthly basis.

13. *Extra time and substitution.*—If physicians, surgeons or dentists are assigned to substitute work or extra hours, authorization will be given by the medical director and physicians, surgeons or dentists will receive their regular hourly rate of pay.

14. *Compensation for home calls, nonroutine hospital visits, office visits, and consultations.*—A report of these visits must be transcribed into the medical record before compensation is made.

15. *Salaries of personnel.*—This schedule does not cover any administrative personel such as department heads, temporary appointees, associates, consultants, etc. These salaries will be defined through recommendation of the medical director.

16. *Section heads.*—Section heads' hourly rate will be $1 per hour. Section heads now receiving $2 under the base medical center and hospital hourly rate plan will remain at the same rate until position is vacated.

17. *Surgeons under the separated medical center and hospital rate plan.*—These surgeons will be compensated at the scheduled medical center hourly rate for vacations, holidays, sick leave, authorized leave or absences and weekly staff conferences.

Computing the Medical Center and Hospital Rate Plan

Since it is expected that Labor Health Institute utilization during the 1952 fiscal year will not differ markedly from that of the calendar year 1951, the 1951 experience is used as a guide in computing the rates for the various compensation plans.

Time Limit to Medical Center and Hospital Rates Computed

The computed rates should be considered valid for the fiscal year 1952–53 only. Compensation of Labor Health Institute doctors according to the "going rate" requires the annual determination of the "going rates" to be used and the annual review of the previous year's distribution of hours and fees.

Source: St. Louis Labor Health Institute: Unpublished data, 1952.

Exhibit D.—*Definition of services provided for illness, Labor Health Institute, St. Louis*

General medical and specialist services in office, home, and hospital: general medicine provided at the medical center by a personal physician chosen by patient, and responsible for all referrals to other sections, except in emergency cases, for periodic physical examinations, diagnosis, treatment, complaints, and followups. Specialties include internal medicine; dermatology; allergy; neuropsychiatry; pediatrics; general surgery, gynecology and obstetrics; ear, nose, and throat; orthopedics; urology; ophthalmology, radiology; clinical laboratory; and dentistry.

Surgery: diagnosis and treatment by members of medical center staff.

Eye care: treatment, eyetesting and surgery. Glasses provided at discount by optician who keeps office hours at center once a week.

Pediatric service: routine physicals with chest X-rays for all children over six, and Kahns and blood counts when indicated. Pediatricians act as personal physicians to pediatric patients with effort made to assign children in same family to one physician. Pediatrician visits hospital to make initial checkup of newborn infant. Home calls by pediatricians and visiting nurse upon request; but special educational services designed to acquaint mother with illnesses that can be handled at the medical center or by telephone reduce number of home-call requests.

Gynecology and obstetrics: gynecology examinations part of routine physical examination for all female patients. Physicians in the department do both obstetric and gynecology work. Obstetrics include delivery, prenatal and postnatal care.

Laboratory services: all usual clinical tests. X-rays: processed and interpreted upon request of physician; superficial X-ray therapy at center, referral to outside sources for deep therapy.

Home care: visits by Labor Health Institute doctors at all times; visits by nurses from Visiting Nurse Association available to regular members within defined geographical area from 8 a. m. to 8 p. m. daily, including Saturdays, Sundays, and holidays. Visiting nurse services include instructions on care of sick, health education, care for acute and posthospital cases including newborn infants, routine visits to chronically ill. Referrals for service through supervisory nurse.

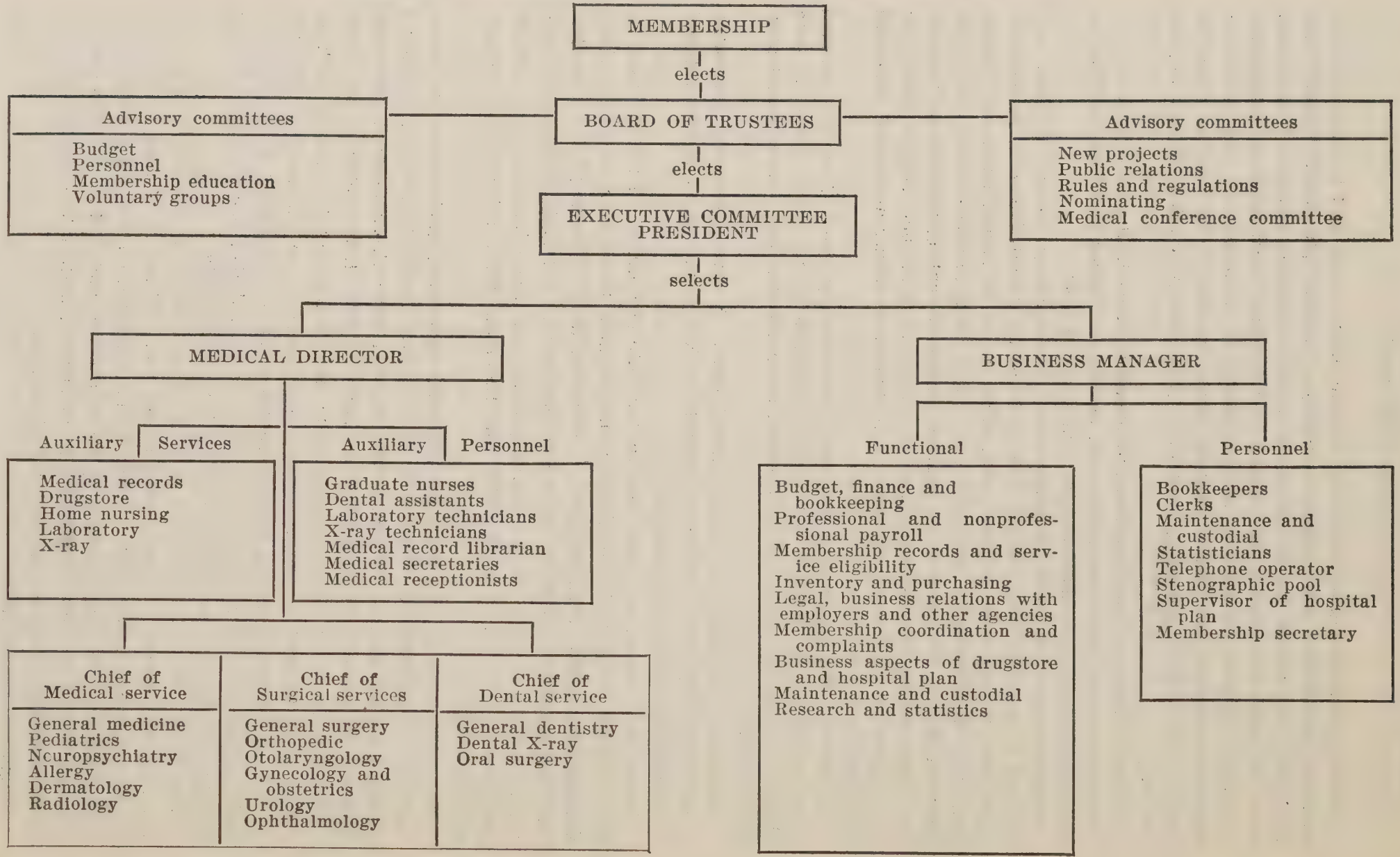
Hospitalization, in local hospitals: up to 90 days during each membership year, one-third of semiprivate room rate in a general hospital for an additional 6 months; hospitalization was provided through Blue Cross prior to February 1949 when institute established its own service plan. Institute's hospital representative makes all hospital arrangements, discusses hospital procedure with patient, visits patient in hospital and reports weekly to the medical director. Except in emergency cases, hospitalization must be authorized at professional staff conferences. Doctor on case visits patient daily; use of Labor Health Institute doctor not necessary to obtain hospital benefits.

Dental services: examinations, X-rays, extractions, and preventive care. All new patients receive dental examination and full-mouth X-rays as part of routine physical examination. After initial examination, patient is assigned to a personal dentist. Information on dental services included in patient's general record. Dental services provided free of charge; materials and drugs at cost. Until 1951, 50¢ charge for fillings; now given free.

Drugs: at special rates.

Source: St. Louis Labor Health Institute: *Annual Report, 1950.* Mimeographed.

Exhibit E.—Organizational Chart, Labor Health Institute, St. Louis.



Source: St. Louis Labor Health Institute: Annual report, 1950, Mimeographed.

Exhibit F.—*Description of functions of administrative personnel, Labor Health Institute, St. Louis*

A. President

Although the president is a nonpaid officer of the Labor Health Institute, he is an active administrator and supervises and coordinates all activities of the institute. At the present, the postition of business manager is vacant and, therefore, all nonprofessional administrative activities are carried out under the direct supervision of the president.

B. Administrative Assistants

To assist in the actual execution of policies and day-to-day operations, the president has two administrative assistants. One works with the medical director on administering the nonmedical activities of the professional services, professional personnel, and auxiliary service and personnel. The other confines his activities to the business operation of the institute.

C. Membership Secretary

The membership secretary is responsible for all membership relations. Complaints are received by the secretary, investigated and presented for discussion and disposition at the weekly complaint committee meetings held by the medical director.

He is also responsible for the maintenance of an accurate membership roll for purposes of checking eligibility of membership for service. He informs the staff when new firms are admitted to the plan for service.

He meets with union groups to inform membership of procedures and benefits available to them.

He works with the medical director on patients' social problems.

D. Medical Director

The medical director initiates appointments of all professional personnel, physicians, dentists, and technical assistants under policies established by the board of trustees to carry out the purposes and programs of the Labor Health Institute. He supervises the functioning of the medical center and has final authority on the extent of medical services to be rendered to any individual. He also participates in the rendering of medical service to patients.

The medical director makes monthly reports to the board of trustees and represents the Labor Health Institute at professional meetings, local and national health agencies.

The medical director holds weekly professional staff meetings attended by all of the professional staff. At these meetings, administrative policy changes are conveyed to the staff. The primary purpose of this weekly staff meeting is to discuss all cases pending hospitalization, and those hospitalized, and discharged. Special cases or unusual cases are also discussed.

Complaint committee meetings, attended by the heads of departments, are held weekly to act upon the members' complaints and suggestions.

The medical director also holds a weekly meeting with the record librarian, the hospital service secretary and the chiefs of the medical service, the surgical service and the dental service for the purpose of reviewing all home care cases and authorizing hospitalization where necessary.

E. Business Manager

The business manager is responsible for the business administration of the Labor Health Institute working with the medical director on all phases of this activity.

He directs the business office which provides the following services:

(1) Finance and bookkeeping
(2) Membership records
(3) Janitorial and maintenance service
(4) Purchasing
(5) Licenses, permits, and insurance
(6) Legal aspects
(7) Switchboard

He is in charge of handling the necessary business or commercial relations with participating employers and other agencies. He is also in charge of the membership roll, and coordinator of membership control.

He cosigns all checks with the secretary-treasurer.

He directs business aspects of the Hospital Service Plan.

Source: St. Louis Labor Health Institute: Unpublished data, 1953.

Exhibit G.—*Description of record-keeping procedures and patient control through the use of records, Labor Health Institute, St. Louis.*

Record-keeping Procedures

I. *Record forms*

A. Exterior:

1. Manila folder and metal file fastener.
2. Upper left hand corner in print—patient's name and place of employment and date of admission.
3. Upper right hand corner—medical record number.

B. Bound portion of medical record. Record is bound in a chronological order of treatment and visits to medical center:

1. Diagnostic face sheet.
2. Physical examination sheet.
3. Progress sheets in chronological order.
4. Allergy sheet in chronological order with progress sheets.
5. Dental sheet.
6. EKG report.
7. Laboratory sheet.
8. Pregnancy record—past, in chronological order with progress sheets.
9. Syphilitic treatment, in chronological order with progress sheets.
10. Correspondence and authorizations.
11. Completed X-ray sheets.
12. Completed injection sheets.
13. Consultants' reports.

C. Loose sheets of medical record:

1. X-ray sheet—current.
2. Nurse's sheet—current
3. Progress sheet—current.
4. Pregnancy record—current.

II. *Recording of clinic visits*

A. Each visit to clinic is recorded in chronological order on the progress sheet.

B. Each visit should show chief complaint, examination, diagnosis, treatment given, date patient is to return to clinic, statement of work status of patient.

C. Physical examinations are recorded on the special sheet made up for that purpose.

D. Discharge note is made when patient completes treatment in one clinic; note of referral back to physician in charge should be made.

III. *Recording of Hospitalization*

A. All hospital notes are to be dictated; notes are then recorded in red type in chronological order on progress sheet; and signed by the attending physician.

B. Surgical cases:

1. Preoperative examination.
2. Routine laboratory examination.
3. Preoperative diagnosis.
4. Medical staff approval.
5. Recording of operative procedure and anesthesia used.
6. Record of all findings.
7. Pathological report of all tissue removed.
8. Result.
9. Discharge note.
10. Signature of surgeon.

C. Pregnancy cases:

1. History of pregnancy as recorded on pregnancy sheet.
2. History of labor, including description of first, second, and third stages.
3. Provisional diagnosis indicating position and presentation of the child.
4. Indications for operative procedures when carried out.
5. Postpartum progress.
6. Condition on discharge.

D. New-born records:

Must show physical examination; height, weight, any abnormalities and feeding, progress notes of baby.

E. Medical cases:

Entrance complaint, provisional diagnosis, progress notes, consultations, special examinations, treatment given, final diagnosis, condition on discharge.

IV. *Recording of home calls*

Date home call made, time, doctor's name, chief complaint, examination, tentative diagnosis, treatment given, work status of patient, instruction re clinic appointment. All home calls are recorded on the progress sheets.

V. *Consultation reports* (Made outside medical center)

A. Abstract of patient's record is sent for consultation prior to patient's appointment.

B. Consultant's report is recorded in record on progress sheets showing findings, diagnosis, and recomendations.

VI. *East St. Louis services*

East St. Louis services are recorded in the medical record in chronological order on the progress sheet.

Patient control through the use of records

I. *New patients:*

A. Records of all new patients are checked within 24 hours.

1. Records checked for completion of:
   Identification.
   Temperature, pulse, respiration, weight, height.
   Laboratory-urine, serology-blood, other.
   Chest X-ray.

Dental examination and X-ray.
Record of chief complaint and present illness.
Record of past history.
Record of physical examination and findings.
Recommendations for further studies.
Provisional diagnosis.
Treatment given.
Date patient is to return.

B. Name of patient with deficient records referred to followup for contact and making of appointment.

C. Deficient records referred to doctors.

D. Records of all new patients checked at one-month and six-month intervals for treatment results obtained and for information on discharge of patients.

II. *Returned patients:*

A. A check is made of appointments kept.

B. Patients are notified to return to clinic when reports on pathology indicate necessity.

C. A followup is made of patients with provisional diagnosis.

D. Patients requiring X-ray or yearly checkup are reported to followup department.

Source: St. Louis Labor Health Institute: *The Labor Health Institute in Action,* report based on 1949 figures activities (May 1), 1950. Mimeographed.

Exhibit H.—*Measurements for appraising the quality of service furnished by group-practice prepayment plans. Developed by Drs. Farish and Goldmann for Labor Health Institute survey*

1. That the physicians affiliated with the plan shall be organized as a definite medical staff, using the word "staff" in an all-inclusive sense to include active, associate, and courtesy medical staff.

2. That the membership of the medical staff shall be restricted to physicians who are (*a*) graduates of medicine of approved medical schools, with degree of doctor of medicine, in good standing, and legally licensed to practice in the State; (*b*) competent in the branch of medicine to which appointment to the staff has been made; and (*c*) worthy in character and matters of professional ethics.

3. That the medical staff initiate and, with the approval of the board of the plan, adopt rules and regulations governing the professional services and that these rules and regulations specifically provide that (*a*) medical staff meetings be held at least once each month, (*b*) the medical staff review and analyze at regular intervals their experience in the various departments of the clinic and in the hospital, and (*c*) the medical records of patients to be the basis for such review and analysis.

4. That the physical plant and equipment be adequate.

5. That diagnostic and therapeutic facilities under competent medical supervision be available for the study, diagnosis, and treatment of patients, these to include at least a clinical laboratory providing chemical, bacteriological, and serological services; and an X-ray department providing radiographic and fluoroscopic services.

6. That provision be made for quantitatively adequate service to insure completeness, continuity, and consistency of service.

7. That patients requiring hospitalization be admitted to institutions approved by the American College of Surgeons.

8. That accurate and complete medical records be written for all patients and filed in an accessible manner. A complete medical record is defined as one which includes identification data; complaint; personal and family history; history of present illness: physical examinations; special examinations, such as consultations, clinical laboratory, X-ray, and other examinations; provisional or working diagnosis; treatment plan, including gross and microscopic pathological findings; progress notes; final diagnosis; and followup.

Source: Farish, Henry G., M. D., and Goldmann, Franz, M. D.: *The Labor Health Institute: Quality of Service.* St. Louis, The Institute, 1948. 29 pp.

Exhibit I.—*Summary of findings of study of Labor Health Institute made by Henry G. Farish, M. D., and Franz Goldmann, M. D.*[1]

1. All the physicians, dentists, nurses, and technicians on the regular staff of the Labor Health Institute possess the qualifications and experience necessary for the proper performance of their duties. A remarkably large proportion of the physicians are specialists meeting the requirements of the specialty boards. Only the laboratory technician, a recent graduate, lacks wider experience, and steps will have to be taken to remedy this situation. The number of professional personnel available for direct service to patients meets accepted standards of adequacy.

2. The physical facilities and the equipment of the Labor Health Institute are good except for the clinical laboratory which stands in need of improvement.

3. All the hospitals at present utilized for service are fully approved by the American College of Surgeons and, accordingly, the quality of service for hospitalized patients can be assumed to be good. It is strongly recommended to continue the policy of utilizing only first-grade hospitals in the future.

4. The service offered to the members of the Labor Health Institute and other patients is broad in scope and readily accessible. Noteworthy is the inclusion of preventive as well as therapeutic services in the program. The amount of service actually received by the persons covered by regular payment plans is such as to place the Labor Health Institute in the top bracket of group-practice prepayment plans and comes close to ideal standards. This is all the more remarkable as the membership of the Labor Health Institute is made up of persons with low incomes.

5. The physicians and dentists affiliated with the Labor Health Institute are organized as a definite staff working in systematic association on the basis of group practice. There appears to be an earnest effort to weld the staff members into a group and develop teamwork through frequent consulations and regular staff conferences.

6. The administrative organization of the professional services has many commendable features, namely, the strictly observed appointment system and the well-organized followup system, the comprehensiveness of the initial examination, the allocation of sufficient time for service to the individual patient, the emphasis on the establishment and maintenance of the patient-physician relationship, the maintenance of comprehensive medical records, and the regular staff conference designed to foster cooperation of all staff members as well as effective and good service to the patient.

On the other hand, there are some shortcomings which ought to be eliminated. In order to develop more effective self-government a formal basis for the activities of the Professional Association of the Labor Health Institute should be created by adding a pertinent clause to the bylaws of the Labor Health Insti-

[1] The survey was made in 1948 at the request of the Labor Health Institute. The weaknesses pointed out have been corrected according to a recent statement by the institute.

tute. In order to assure harmonious cooperation between the physicians and dentists on the staff, the medical director, and the board of trustees, the powers, functions, duties, and rights of each group should be clearly defined in rules and regulations elaborating on general policies to be set forth in the bylaws of the Labor Health Institute.

Source: Farish, Henry G., M. D., and Goldmann, Franz, M. D.: *The Labor Health Institute: Quality of Service.* St. Louis, The Institute, 1948. 29 pp.

Table 1.—*Total annual income and expenses, Labor Health Institute, St. Louis, 1950 and July 1, 1951–June 30, 1952*

	1950	1951–52
Income, total	$631, 214	$874, 504
Dues:		
Regular members	592, 314	821, 998
Special members	19, 103	26, 924
Associate members	725	401
Medical fees	17, 992	19, 924
Other income	1, 079	5, 257
Operating expenses, total	446, 184	733, 203
Medical and dental expenses	346, 583	559, 543
Physicians and dentists	167, 025	253, 514
Technicians	43, 073	72, 558
Social worker department [1]		6, 957
Medical records and receptionists	11, 744	27, 841
Supplies	31, 839	50, 029
Administrative	92, 902	148, 644
Medical and dental [2]	NA	12, 421
Business [3]	NA	136, 223
Hospital expenses	99, 601	173, 660
Payments to hospitals	NA	136, 651
Administrative expenses	NA	10, 536
Reserve	NA	26, 473
Reserves and expansion fund	116, 181	131, 939
Undivided income	68, 849	9, 362

[1] Discontinued August 15, 1951.
[2] Includes only payments to medical director, chiefs of medical, surgical and dental services.
[3] Includes all non-direct medical expenses such as rent, depreciation.

Sources: St. Louis Labor Health Institute: Annual report, 1950, Mimeographed; Unpublished data March 1953.

Table 2.—*Average cost of medical and dental services and hospitalization, exclusive of reserves, Labor Health Institute, St. Louis, 1949, 1950, and July 1, 1951–June 30, 1952*

Item	1949	1950	1951–52
Medical and dental services:			
Average number of persons eligible for care	6, 070	9, 058	14, 203
Cost per eligible person	$44. 00	$38. 26	$39. 40
Cost per person receiving service	$78. 00	$64. 27	$63. 20
Cost per patient visit, total [1]	$5. 72	$4. 94	$5. 42
Hospitalization:			
Average number of persons eligible for hospitalization	[2] 7, 120	9, 959	14, 105
Cost per eligible person	$9. 72	$10. 00	$10. 44
Cost per day per case	$15. 18	$12. 73	$12. 31
Cost per hospital case	$126. 00	$106. 00	$95. 87

[1] Medical and dental expenses divided by the number of visits excluding visits to the nurse, not counted as separate visits.
[2] 11-month average.

Source: St. Louis Labor Health Institute: Annual report, 1950, Mimeographed unpublished data, March 1953.

Table 3.—*Payments to staff physicians and dentists, by department, Labor Health Institute, St. Louis, July 1, 1951–June 30, 1952*

Department	Total doctor and dentist fees	Medical center and hospital patient care	Staff meeting	Administrative (includes section head)	Vacation, sick, holiday, and other paid leave	Home patient care	Private office patient care
Total [1]	$256,612	$155,120	$11,256	$35,798	$11,605	$20,730	$5,999
Internal medicine	52,890	31,522	2,370	2,720	3,695	12,537	46
Gynecology and obstetrics	24,823	21,023	1,119	585	662	897	537
Pediatrics	19,680	10,291	945	810	565	6,420	649
Eye	17,997	13,812	1,760	714	1,560	88	63
General surgery	13,521	11,705	732	559	363	90	72
Ear, nose, and throat	9,471	7,284	1,274	----	616	190	107
Genitourinary	8,046	5,770	676	764	795	5	36
Neuropsychiatry	7,266	5,700	502	576	408	20	60
Orthopedics	7,119	4,295	218	399	406	----	1,801
Dermatology	2,693	2,040	510	----	90	5	48
Allergy	1,623	1,623	----	----	----	----	----
Neurosurgery [2]	540	484	56	----	----	----	----
X-ray	7,480	4,696	470	1,064	445	----	805
Dentistry	37,104	33,696	624	----	2,000	96	688
Medical administration	21,007	----	----	21,007	----	----	----
East St. Louis	3,248	1,179	----	600	----	382	1,087

[1] Adjusted to exclude payments in fiscal year applicable to service rendered in other years; includes $16,104 paid to physicians not on Labor Health Institute staff.
[2] Started in February 1951 and discontinued September 1951.

Source: St. Louis Labor Health Institute: Unpublished data, March 1953.

Table 4.—*Total payments to staff physicians and dentists and average income per full-time equivalent physician and dentist, by department, Labor Health Institute, St. Louis, July 1, 1951–June 30, 1952*

Department	Total doctor fees	Number of full-time equivalent doctors, 1951	Average 1951–52 income per full-time equivalent doctor in 1951 [2]	United States average net income of specialists, 1951
Total [1]	$256,612	15.99	$13,149	----
Internal medicine	52,890	4.90	10,794	$12,069
Gynecology and obstetrics	24,823	1.43	17,359	15,413
Pediatrics	19,680	1.25	15,744	11,820
Eye	17,997	0.77	23,372	14,448
General surgery	13,521	.76	17,791	16,514
Ear, nose, and throat	9,471	.64	14,798	12,777
Genitourinary	8,046	.43	18,712	14,466
Neuropsychiatry	7,266	.36	20,183	14,500
Orthopedics	7,119	.36	19,775	16,188
Dermatology	2,693	.14	19,236	13,250
Allergy	1,623	.13	12,485	13,458
Neurosurgery [3]	540	----	----	----
X-ray	7,480	.31	24,129	17,675
Dentistry	37,104	4.51	8,227	6,708

[1] Adjusted to exclude payments in fiscal year applicable to service rendered in other years; includes $16,104 paid to physicians not on LHI staff, $27,007 paid to medical administrator and staff and $3,248 paid to East St. Louis doctors.
[2] Average excluding medical administrator and staff, East St. Louis doctors and non-Labor Health Institute referrals.
[3] Started in February 1951 and discontinued September 1951.

Source: St. Louis Labor Health Institute: Unpublished data, March 1953.

Table 5.—*Number of physicians and dentists employed and schedule of clinic hours, Labor Health Institute, St. Louis, July 1, 1952*

Department	Number of physicians and dentists	Schedule of clinic hours					
		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
General Medicine	10	10–6	9–6	10–6	9–6	11–6	9–12
Eye	4	10–12	10–12	10–1	10–12	10–12	9–12
		3–6	3–6	3–6	3–6	3–6	
Gynecology and obstetrics	5	11–1					9–12
		3–6	3–6	3–6	3–6	3–6	
Pediatrics	6	9–2	12–2	9–2	11–2	12–2	9–12
Ear, nose, and throat	3	3:30–6	3–6	3:30–6	3–6	3–6	9–12
General surgery	3	3–6	4–6	3–6	3–6	3–6	10–12
Orthopedics	2	3–6	4–6	3–6	3–6	3–6	10–12
Genitourinary	2	3:30–6	3–6	10:30–12:30	3–6	3–6	10:30–12
Neuropsychiatry	3		3–6	2–6	3–6		9–12
Radiology	1	4:45–5:45	4:45–5:45	4:45–5:45	4:45–5:45	4:45–5:45	9–10
Allergy	2	3–6		4–6			
Skin	1	4–6			4–6		
Dentistry	8	9–1	9–1	9–1	9–1	9–1	9–12
		2–6	2–6	2–6	2–6	2–6	

Source: St. Louis Labor Health Institute. Annual report, 1950. Mimeographed.

Table 6.—*Allocation of physicians' and dentists' hours at medical center, Labor Health Institute, St. Louis, July 1, 1951–June 30, 1952*

Department	Total paid hours [1]	Patient-hours			Staff meeting hours	Paid-leave hours			
		Number per 1,000 eligibles [2]	Number			Vacation	Sick	Holiday	Other
			Regular	Substitute					
Percent of total doctor medical center hours	100.0		84.3	1.6	6.5	4.2	.9	2.3	.2
Total	25,715	1,555	21,678	416	1,673	1,080	219	586	63
Internal medicine	7,445	439	6,213	19	474	487	31	185	36
Eye	1,705	97	1,361	12	176	60	54	37	5
Gynecology and obstetrics	1,530	85	1,159	49	203	59	16	39	5
Pediatrics	1,206	69	980	2	142	46	19	15	2
General surgery	974	54	771		137	46		20	
Ear, nose, and throat	972	54	756	17	136	33	7	23	
Genitourinary	723	40	542	33	68	49	6	22	3
Neuropsychiatry	695	42	592	6	52	25	2	16	2
Radiology	560	33	440	28	47	32		13	
Orthopedics	327	18	255	4	24	30	3	11	
Dermatology	262	14	202		51			9	
Allergy	253	18	253						
Neurosurgery [3]	58	4	51		7				
Dentistry	9,005	588	8,103	246	156	213	81	196	10

[1] Excludes hours of medical administration, 2,227 hours in 1951–52.
[2] Based on 12-month average eligibles of 14,203.
[3] Started in February 1951 and discontinued September 1951.

Source: St. Louis Labor Health Institute: Unpublished data, March 1953.

Table 7.—*Full-time equivalent physicians and dentists and total hours worked,[1] Labor Health Institute, St. Louis, 1951*

Specialty	Equivalent full-time physicians and dentists [2]	Hours				
		Total	Medical center	Outside		
				Home	Office	Hospital
Total	15.99	33,226	26,464	[3] 3,360	323	3,079
Internal medicine	4.90	10,182	7,742	2,241	3	196
Gynecology-obstetrics	1.43	2,979	1,439	87	62	1,391
Pediatrics	1.25	2,606	1,205	971	66	364
Eye	.77	1,610	1,547	10	2	51
General surgery	.76	1,585	978	15	5	587
Ear, nose, and throat	.64	1,340	1,032	26	50	236
Urology	.43	885	772	1	1	111
Neuropsychiatry	.36	748	700	1	2	45
Orthopedics	.36	738	618	----	32	88
Dermatology	.14	285	277	----	7	1
Allergy	.13	260	253	----	----	7
X-ray	.31	637	565	----	72	----
Dentistry	4.51	9,371	9,336	8	21	6

[1] Excluding administrative staff.
[2] Based on 2,080 hours a year including vacations.
[3] 2,914 day, 446 night.

Source: St. Louis Labor Health Institute: Doctor's Fee Study, July 1952–June 1953. Mimeographed.

Table 8.—*Annual number of patient visits,[1] classified according to medical department, Labor Health Center, St. Louis, Mo., 1950*

Medical department	Number of visits per 1,000 eligible persons [2]				
	Total visits	Medical center visits	Hospital visits	Home visits	Office visits
Internal medicine	2,003.0	1,783.9	79.6	137.7	1.8
Ear, nose, and throat	555.1	502.6	45.0	----	7.4
Gynecology and obstetrics	483.8	338.5	141.3	2.1	1.9
General surgery	474.6	314.2	156.3	3.4	.7
Pediatrics	408.3	300.2	53.1	53.3	1.7
Eye	310.4	291.5	18.1	.1	.8
Orthopedics	244.9	200.6	43.6	.4	.2
Genitourinary	174.7	146.2	28.3	.1	.1
Dermatology	118.8	112.4	4.6	----	1.8
Neuropsychiatry	94.7	78.8	15.6	.1	.2
Allergy	76.4	75.5	.9	----	----
X-ray	530.5	523.3	NA	NA	NA
Dentistry	1,374.4	1,369.5	----	----	4.9

[1] Excludes visits to the medical administration, visits of East St. Louis physicians and non-LHI referrals.
[2] Based on 12-month average eligibles of 9,058.

Source: St. Louis Labor Health Institute: Annual report, 1950. Mimeographed.

Table 9.—*Number of patient visits, classified according to medical department, Labor Health Institute, St. Louis, July 1, 1951–June 30, 1952* [1]

Medical department	Number of visits per 1,000 eligible persons [2]						
	Medical center patient visits	Hospital			Out-patients	Home patient visits	Office patient visits
		Inpatient days of care	Inpatient number of cases	Consultations			
Internal medicine	1,522.5	82.7	5.7	3.1	0.3	162.6	0.9
Pediatrics	387.8	134.0	19.2	.6	.6	88.8	15.0
Gynecology and obstetrics	353.9	199.5	29.0	5.5	.5	10.0	10.8
Ear, nose, and throat	334.2	22.8	8.2	.8	1.5	2.6	2.4
Eye	333.0	7.0	1.2	.4	.9	.8	.9
General surgery	275.4	107.7	13.3	1.3	2.3	1.1	.6
Genitourinary	131.7	23.5	2.6	.1	.1	.1	.4
Dermatology	116.9	1.8	.1	.1	----------	.1	1.1
Orthopedics	90.0	22.2	2.0	.3	1.8	----------	17.7
Neuropsychiatry	83.7	6.5	.6	.8	----------	.2	.3
Allergy	69.4	2.4	.1	.1	----------	----------	----------
Neurosurgery [3]	4.4	4.1	.1	.1	----------	----------	----------
X-ray	379.1	----------	----------	.1	----------	----------	7.6
Dentistry	1,261.5	.4	.2	----------	----------	.8	3.7

[1] Excludes visits to the medical administration, visits of East St. Louis physicians and non-LHI referrals.
[2] Based on 12-month average eligibles of 14,230.
[3] Started in February, 1951 and discontinued September 1951.

Source: St. Louis Labor Health Institute: Unpublished data, March 1953.

Table 10.—*Number of dental services provided at Labor Health Institute, St. Louis, 1950 and July 1, 1951–June 30, 1952*

Type of service	1950		1951–52	
	Number	Per 1,000 eligible persons [1]	Number	Per 1,000 eligible persons [2]
Total	36,850	4,068.2	51,493	3,625.5
Anesthesia, local	2,510	277.1	5,222	367.7
Consultations	339	37.4	635	44.7
Denture adjustments	707	78.1	1,034	72.8
Dentures received	391	43.2	798	56.2
Examinations	759	83.8	1,233	86.8
Extractions	3,342	369.0	4,758	335.0
Fillings	3,662	404.3	6,972	490.9
Fluorine treatments	126	13.9	128	9.0
Gum treatments	976	107.8	866	61.0
Impressions	735	81.1	1,051	74.0
Full-mouth X-rays read	1,501	165.7	1,455	102.4
Postoperative treatments	441	48.7	820	57.7
Prophylaxis	864	95.4	1,096	77.1
Prosthetic fittings	576	63.6	1,376	96.6
Root treatments	29	3.2	7	.5
Scaling	851	94.0	942	66.3
Surgery	120	13.2	247	17.4
Tooth treatments	1,151	127.5	2,571	181.0
X-ray plates taken	17,613	1,944.5	20,086	1,414.2
Miscellaneous	153	16.9	196	13.8

[1] Based on 12-month average of 9,058 eligibles.
[2] Based on 12-month average of 14,203 eligibles.

Source: St. Louis Labor Health Institute: Annual report, 1950, mimeographed; unpublished data, March 1953.

Table 11.—*Number of X-ray services provided at Labor Health Institute, St. Louis, 1950 and July 1, 1951–June 30, 1952*

Type of service	1950		1951–52	
	Number	Per 1,000 eligible persons [1]	Number	Per 1,000 eligible persons [2]
Total plates	7,754	856.0	10,095	710.8
Barium enema	261	28.8	322	22.7
Bone	916	101.1	1,221	86.0
Chest	2,889	318.9	3,014	212.2
Fluoroscopes	383	42.3	559	39.4
Gall bladder	328	36.2	512	36.0
Gastrointestinal	1,008	111.3	1,732	121.9
I. V. pyelograms			341	24.0
K. U. B	52	5.7	78	5.5
Sinus	475	52.4	743	52.3
Skull	151	16.7	189	13.3
Spine	670	74.0	893	62.9
X-ray therapy	190	21.0	182	12.8
Miscellaneous	531	58.6	309	21.8

[1] Based on 12-month average of 9,058 eligibles.
[2] Based on 12-month average of 14,203 eligibles.

Source: St. Louis Labor Health Institute: Annual report, 1950, mineographed; unpublished data, March 1953.

Table 12.—*Number of laboratory services provided at Labor Health Institute, St. Louis, 1950 and July 1, 1951–June 30, 1952*

Type of service	1950		1951–52	
	Number	Per 1,000 eligible persons [1]	Number	Per 1,000 eligible persons [2]
Total	18,345	2,025.3	21,600	1,520.8
Blood chemistry and sugars	450	49.7	909	64.0
Differential	2,968	327.7	2,999	211.2
Gastric analysis	22	2.4	35	2.5
Hematocrit	19	2.1	45	3.2
Hemoglobin	2,986	329.7	3,260	229.5
Kahn (taken only)	2,696	297.6	2,438	171.7
Red blood count	813	89.8	994	70.0
Sedimentation rate	97	10.7	219	15.4
Smears	153	16.9	208	14.6
Spinal fluid	36	4.0	27	1.9
Sputum	69	7.6	67	4.7
Stool	75	8.3	137	9.6
Urine	4,590	506.7	6,527	459.6
White blood count	2,996	330.8	3,027	213.1
Miscellaneous	385	42.5	708	49.8

[1] Based on 12-month average of 9,058 eligibles.
[2] Based on 12-month average of 14,203 eligibles.

Source: St. Louis Labor Health Institute: Annual report, 1950, mimeographed; unpublished data, March 1953.

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Industry-wide Programs

Introduction

The descriptions of two other union programs have been included in this volume because of their size and their wide general interest, those of the International Ladies' Garment Workers' Union and of the United Mine Workers of America Welfare and Retirement Fund.

These programs are dissimilar from any of those previously described, in that they cover a wider geographic area. The International Ladies' Garment Workers' Union has programs in operation in 14 cities under which more than 400,000 members are eligible for service. The ILGWU health centers in Boston and New York City were included in the program previously described. The United Mine Workers of America Welfare and Retirement Fund makes medical services available through local doctors and hospitals in 26 States to about 1.5 million miners and their dependents.

Health Services and Welfare Benefits of the International Ladies' Garment Workers' Union*

1710 Broadway
New York, N. Y.

A resolution adopted at the International Ladies' Garment Workers' Union Convention in 1944 called on all locals to make health and welfare benefits key demands in the renewal of contracts. Prior to this, a few locals had bargained for such benefits. Other locals, such as those in New York City, were sponsoring their own health and welfare programs.

By the beginning of 1953, more than 95 percent of the 430,000 International Ladies' Garment Workers' Union members were protected by health and welfare benefits under collective bargaining agreements; 402,000 members were eligible for benefits from union-administered funds, and 19,500 through insurance carried by employers. Approximately 350,000 members resided in areas where union health centers were already existing or were under construction.

Union health centers

In the early part of 1953, health centers were in operation in 14 United States cities; three other centers, in Chicago, Houston, and Montreal, were scheduled to open in the near future. Most of the centers provide preventive and diagnostic services; the Union Health Center in Boston, described on pages 83–88, is a center of this type. A few, including the New York center (available to almost 50 percent of the members of the International Ladies' Garment Workers' Union), also offer medical care to ambulatory patients. A description of the New York center is on pages 135–151.

The health centers now in operation or scheduled to open in the near future are located in: Allentown-Easton, Philadelphia, and Wilkes-Barre, Pa.; Boston and Fall River, Mass.; Dallas, Houston, and San Antonio, Tex.; Kansas City and St. Louis, Mo.; Chicago, Ill.; Cleveland, Ohio; Los Angeles, Calif.; Minneapolis, Minn.; Newark, N. J.; and New York, N. Y. The address of the established centers and the names of the medical directors are given in exhibit A.

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*Adolph Held, Supervisor, Health and Welfare Funds, Health and Welfare Committee.

Diagnostic and preventive services also are made available to members in many areas through automobile units which visit places of business. Each worker who chooses to participate is interviewed by a medical case worker who takes a complete medical history. A medical technician then carries through various laboratory studies including urinalysis and blood counts. If the medical history indicates that other tests are needed, samples are taken for central laboratory determination. The completed histories and reports are analyzed by the union's medical director. A report of the findings is sent to the member's family physician and the member is urged to see him if medical attention is necessary. Areas provided with such services include Harrisburg, Sayre, Shamokin and Sunbury, Pa.; Springfield, Mass.; Utica, N. Y.; Trenton, N. J.; and Wilmington, Del.

Other health and welfare benefits

Other health and welfare benefits vary from community to community and among the locals within a community. General categories include disability benefits, hospitalization, maternity benefits, surgical benefits, eye examination and care, tuberculosis benefits. Vacation benefits are an integral part of many of the programs and retirement benefits, a relatively recent development, are now available to many members. The health centers, in addition to providing diagnostic and medical services, also process sick-benefit claims from welfare funds.

Administration

Local and joint boards negotiate collective bargaining agreements and are responsible for the health programs in their respective districts. Health and welfare committees set up by these locals or joint boards are considered by the union to be a key factor in the sympathetic and sound operation of the programs. A health and welfare committee of the general executive board of the International Ladies' Garment Workers' Union was set up in 1945 to coordinate standards meeting requirements of a large and varied body of State and national laws, and to insure uniform financial and record keeping procedures.

The director of the welfare and health benefit department is responsible to the general executive board for the following functions:

1. He receives and analyzes reports on the conditions of the various funds and makes recommendations to the locals, joint boards, departments, etc., of the International Ladies' Garment Workers' Union on the operations of their funds.
2. He makes continuous and periodic audits of the accounts of the various funds, and he supervises the records of the locals.
3. He administers the rules and regulations of the general executive board and its committees which are concerned with these funds.
4. He acts as an informal appellate agency on appeals from the decision of the claims and appeals committee of the locals, joint boards, and other subordinate bodies.

Financing

There has been a rapid growth of health and welfare funds in the years immediately following adoption of the resolution regarding them at the 1944 convention. Annual income of such funds (including vacation benefits) grew from less than $4 million in 1943 to more than $34 million in 1952; disbursements for the same years increased from about $2 million to $26 million. Total reserves at the end of 1952 were over $62 million.

In 1952, members received (in addition to retirement benefits of about $6 million) the following benefits:

	Amount	*Percent*
Total benefits	$25,755,318	100.0
Medical	4,190,869	16.3
Medical care	2,139,027	8.3
Hospitalization	1,064,197	4.1
Surgery	513,133	2.0
Eye conservation	253,058	1.0
Maternity	211,690	.8
Tuberculosis	9,764	(1)
Other welfare benefits	20,276,449	78.7
Vacation	12,204,008	47.4
Sick benefits	4,563,970	17.7
Death benefits	2,159,717	8.4
Other	1,348,754	5.2
Administrative costs	1,288,000	5.0

[1] Less than 0.05 percent.

Exhibit A.—*The location of the International Ladies' Garment Workers' Union Health Centers and the names of the medical directors, 1953*

Location	*Medical directors*
ILGWU Health Center, 1017 Hamilton, Allentown, Pa	N. H. Heiligman, M. D.
ILGWU Health Center, 33 Harrison Ave., Boston 11, Mass	Joseph H. Kaplan, M. D.
Cleveland ILGWU Apparel Industries Health Center, 3233 Euclid Ave., Cleveland, Ohio	J. P. Eichorn, M. D.
ILGWU Health Center, 523½ South Ervay St., Dallas, Tex	Ozro T. Woods, M. D.
ILGWU Health Center, local 178, Garment Workers Square, Fall River, Mass	Samuel Brown, M. D.
ILGWU Health Center, 2215 Steele Boulevard, Kansas City, Mo	Mark M. Marks, M. D.
Los Angeles Union Health Center, ILGWU, 1130 South Maple, Los Angeles, Calif	Max Charles Igloe, M. D.
ILGWU Health Center, 63 South 4th St., Minneapolis, Minn	Arden Miller, M. D.
ILGWU Health Center, Broad and William Sts., Newark, N. J.	Asher Yaguda, M. D.
Union Health Center, ILGWU, 275 7th Ave., New York 1, N. Y.	Leo Price, M. D.
ILGWU Health Center, 925 North Broad St., Philadelphia, Pa.	J. K. Jaffe, M. D.
San Antonio Garment Workers Medical Survey Clinic, 214½ West Commerce St., San Antonio, Tex	Lawrence M. Shefts, M. D.
Garment Industry Medical Center, 4646 Lindell Boulevard, St. Louis 8, Mo	Melvin B. Kirstein, M. D.
ILGWU Health Center, 37 South Washington St., Wilkes-Barre, Pa	Albert R. Feinberg, M. D.

SOURCES

Health and Welfare Committee of the General Executive Board, ILGWU: *Health Services for The Membership of the International Ladies' Garment Workers' Union.* New York City, The Committee, 1950. 54 pp.

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Sackman, Morris: *Welfare Collective Bargaining in Action* (*Research Bulletin No. 3.*) New York, Cornell University, 1949, pp. 12–18.

U. S. Congress, Joint Committee on Labor-Management Relations: *Labor-Management Relations Welfare Funds* (*Report 986, part 4*). Washington, U. S. Government Printing Office, 1948, pp. 38–45.

Correspondence and personal interviews.

Hospital and Medical Care Program of the United Mine Workers of America Welfare and Retirement Fund*

Washington, D. C.

The hospital and medical care program of the United Mine Workers of America Welfare and Retirement Fund pays for hospital care, medical services, primarily in the hospital, and certain prescribed drugs, and for rehabilitation services at special centers. Miners and their dependents are eligible.

The benefits are financed through the welfare and retirement fund, set up under the national bituminous coal wage agreements, to which the mine operators pay a royalty of 40 cents per ton of bituminous coal mined for sale or use. In 1952 a potential of 1.5 million miners and their dependents, living in 26 States, were eligible for services. During the year ending June 30, 1952, about $50 million were spent for the medical and hospital benefits.

The lack of adequate medical and hospital care for miners and their families was highlighted by the report on the medical survey of the bituminous coal industry released in 1947 by Rear Adm. Joel T. Boone, United States Naval Medical Corps. The report found that in the coal-mine regions the practice of medicine on a contract basis led to serious abuses and that three-fourths of the hospitals available to the miners were inadequate in one or more conditions. Moreover, many miners had to be transported for excessive distances in order to receive hospital care.

The report confirmed the findings of the United Mine Workers that (*a*) most miners and their families were receiving little or inadequate medical care, and (*b*) many injured persons who might be restored to activity were allowed to go untreated, because miners could not afford the treatment necessary for restoration of the injured. The high maternal and infant mortality rate, a commonly used index of health levels, also indicated that many miners could not afford even the basic medical services.

Through industrywide collective bargaining, the United Mine Workers in May 1946 established a welfare and retirement fund to which the operators (at the time of agreement, the United States

*John L. Lewis, President, United Mine Workers, and Chairman, Board of Trustees; Charles Owen, Trustee; Josephine Roche, Trustee, and Director of the Fund; Warren F. Draper, M. D., Executive Medical Officer.

Government) agreed to pay into the fund 5 cents per ton of bituminous coal mined. Since that time the royalty rate has been increased to 40 cents a ton. The first benefit payments from the fund were made in May 1947 to the survivors of the Centralia mine disaster.

In December 1948, 10 area medical offices were established to make arrangements with local doctors and hospitals in 26 States for the provision of medical services. Early in 1948, the fund paid for the first medical services.

Basic objectives outlined by plan

In carrying out the purposes of the medical and hospital care program, the area medical administrators are to follow certain broad principles:

1. To arrange for the provision of a satisfactory quality of hospital and medical care through patients' free choice of physicians and hospitals.
2. To utilize the health services of other organizations in the state and county to the extent that they are needed and available.
3. To conduct the program with a minimum of administrative detail and cost.
4. To provide leadership that will stimulate a high quality of medical and hospital service for miners at the most reasonable cost for which such service can be obtained.

In addition, the fund is authorized to assist in the development of facilities and services found necessary to effectuate the purpose of its program.

Eligibility

All miners and their dependents are eligible for medical and hospital care benefits. Prior to January 29, 1953, all active and retired miners, their dependents, and survivors of miners, were eligible for these services. Since January 1953, a miner must have been employed in the coal industry after May 28, 1946, before he, his dependents, or his survivors are eligible. Miners who were eligible for hospital and medical care benefits before January 29, 1953, were not affected by this change in these regulations. Dependents include children and dependent adults who have been dependent upon and living with the miner for one year immediately preceding application. Survivors include widows and dependent children.

Membership

The medical care services of the United Mine Workers program are available to approximately 1.5 million potential beneficiaries, including miners and their dependents. They live in 26 States and Alaska. The average monthly income of miners is about $300.

Method of financing and cost of care

Method of financing.—All funds for the hospital and medical care programs come from the United Mine Workers Welfare and Retirement Fund. Under the terms of the collective bargaining agreement with the bituminous coal operators, the operators make royalty payments of 40 cents for each ton of bituminous coal mined. The fund, as reorganized in 1950, provides for the following benefits to be paid from the royalty revenues: Medical and hospital care, retirement pensions, benefits on the death of the miner, sickness and injury benefits, and benefits for widows and survivors of deceased miners. The three trustees of the fund are: Charles Owen, representing the operators; John L. Lewis, representing the union; and one neutral member, Miss Josephine Roche. They are responsible for authorizing all benefit expenditures. Income of the fund during the year July 1, 1951, to June 30, 1952, was $126.5 million and expenditures, $126.3 million.

Operating costs.—During the 12 months ending June 30, 1952, expenditures for all medical care benefits were $49,996,518. Of these benefits, 85.6 percent were received by working miners and their families; 4.1 percent by widows and orphans of deceased miners; and 10.3 percent by disabled beneficiaries. About two-thirds of the payments were to hospitals and one-third to physicians.

Total expenditures for medical services	$49,997,000
Working miners and families	42,797,000
Survivors of miners	2,050,000
Disabled beneficiaries	5,150,000

The nearly $50 million spent in the fiscal year 1952 for medical benefits excludes both the cost of administering the program and loans made to three hospital associations set up under the auspices of the fund. In 1952, the cost of administering all trust-fund programs amounted to 2.7 percent of total expenditures; this included the cost of the central office and the 10 area medical offices. The loans to the three hospital associations totaled $1,878,890, which covered the acquisition of hospital sites and the services of architects, engineers, and other technical experts.

Payments to physicians.—Physicians in private practice in various communities are paid for services rendered, usually on a fee-for-service basis. Methods of paying physicians on a time basis are being studied. During the fiscal year 1952, physicians were paid about $16.5 million for services rendered fund beneficiaries.

Services provided

Hospital services.—Hospital care is provided for as long as necessary to miners and their dependents. Where possible, the fund uses the existing facilities within the area; where patients cannot be cared for adequately through local facilities, the area office may arrange

for care at a nearby hospital. Cases needing highly specialized service are sent across the country if necessary.

All necessary drugs and other services such as X-rays and laboratory are provided all hospitalized patients.

General medical and specialist care.—Medical care is provided in the hospitals, and specialists' care may also be given outside the hospital. Usually services of specialists are provided when the patient is referred by his attending physician.

Rehabilitation services.—A major emphasis of the United Mine Workers' medical program is the provision of highly specialized rehabilitation measures for paraplegics and otherwise severely handicapped miners and their dependents. The fund program of physical restoration is integrated with the vocational rehabilitation services provided by Federal and State vocational rehabilitation agencies. Severely handicapped beneficiaries requiring special treatment, which is often prolonged and difficult, are transported for long distances by ambulance, train, and airplane. Among the facilities used in providing services to these severely disabled beneficiaries are the Kessler Institute for Rehabilitation, West Orange, N. J.; The Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, New York City; The Kabat-Kaiser Institute, Vallejo and Santa Monica, Calif.; and the George Washington University Hospital, Washington, D. C.

Followup care, prescribed by physicians at the special centers, is given at the home and physician's office to severely handicapped persons for as long as necessary.

Other services.—Certain expensive drugs required for long-continued periods of treatment are provided nonhospitalized beneficiaries.

Physical examinations are made in connection with applications for prescribed cash benefits.

Services not provided.—Those services not provided are: general medical care in the home and office except as noted above; services which the patient may be entitled to receive from an agency of the government, such as treatment for tuberculosis or mental disease in a State or county hospital, or from a private organization, as in the case of tuberculosis, infantile paralysis, and cancer; services for which the employer or others are legally responsible, such as medical service in compensation cases; tonsil and adenoid removal, and dentistry.

Facilities

Where the local facilities are adequate, and satisfactory arrangements can be made, the local hospitals are used; otherwise, patients may be transported to the nearest acceptable hospitals. Representatives of the area medical offices are responsible for visiting the hospitals and arranging with them individually for services and terms.

Only those hospitals with which arrangements have been made may be used by the beneficiaries, although exceptions are made in emergencies.

Because the hospitals in certain mining areas were so inadequate, the fund found it necessary to construct its own hospitals. The Memorial Hospital Associations of Kentucky, Virginia, and West Virginia have been organized on a nonprofit basis in accordance with the laws of their respective States. These associations are responsible for constructing, equipping, and operating 10 new hospitals having from 50 to 200 beds with a total capacity of slightly over 1,000. Money for the hospital projects is provided by the United Mine Workers Welfare and Retirement Fund. Plans for the hospitals have already been drawn, and several of the hospitals are under construction. The hospitals will be located in Harlan, Pikeville, Hazard, Middlesboro, Whitesburg, and Wheelwright, Ky.; in Wise, Va.; and in Beckley, Logan, and Williamson, W. Va.

Staff

Administrative staff.—Each of the 10 area medical offices is in charge of a physician who is an experienced medical care administrator. Under him are an administrative officer, a public health nurse, and additional personnel engaged in administrative and clerical work.

The medical headquarters of the fund in Washington consist of 28 persons including the executive medical officer and two assistant physicians, a dental consultant who works with official health agencies toward the extension of dental services to mining areas, an administrative officer, a hospital consultant, and a rehabilitation consultant.

Professional staff.—In addition to the area medical administrators and the public health nurse, each area office employs 1 or 2 consultants in rehabilitation. No practicing physicians are on the payroll of the fund. Any physician who is selected by a beneficiary and who desires to participate in the program may do so. Since the start of the medical program, about 8,000 physicians have received payment from the fund for services rendered to beneficiaries. A physician may receive payment from the fund for services if he meets the following conditions:

1. He must be in good professional repute.
2. He must indicate his desire or willingness to provide treatment to fund beneficiaries at a charge that is reasonable for the type of patients treated under existing conditions.
3. He must abide by the regulations of the fund in regard to the submission of clinical records and data required for payment of services rendered.

Utilization

During the 12-month period ending June 30, 1952, hospital and medical care was provided to 215,372 persons representing nearly 15 percent of all persons eligible for services. The patients received 2,154,882 days of hospitalization, about 10 days per case. Obstetrical cases accounted for about 12 percent of all hospitalizations, which number approximately 4,400 per week. Additional figures are not available; the fund is not releasing detailed data at this time, but data are continually being compiled and analyzed and are currently available for guidance in the administration of the program.

Administration

All decisions as to benefits are made by the fund trustees. Benefits are subject to termination and revision at the discretion of the trustees.

The program is administered through 10 area offices, each responsible for the activities within a specified area. The physicians in charge of the area offices work under the general direction and supervision of the executive medical officer of the fund at the Washington headquarters office. The area medical administrators make all administrative and operating decisions except those establishing broad general policy.

Records and research

Physicians are required to submit clinical records of all cases handled. These records are primarily for the purpose of authorizing payments and are kept to a minimum.

Other health and welfare benefits

Retirement.—Monthly payments of $100 are made. These are in addition to amounts received from old-age and survivors insurance. As of June 30, 1952, 45,339 retired miners were receiving pensions.

Total disability payments.—Up to $30 a month is paid for totally disabled miners (including those undergoing rehabilitation) plus $10 per month for wives and each dependent child. Any other income is deducted from the maximum allowed. As of June 30, 1952, 18,130 disabled miners were receiving these benefits; 76.5 percent of them were receiving the maximum amount allowed.

Disaster benefits.—Authorized in February 1952, these benefits are payable to families of miners killed or severely injured in mine disasters. At the end of June 1952, about $70,000 had been paid to 611 beneficiaries.

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Appendixes

Appendix 1.—*Workmen's compensation coverage of occupational diseases, by State and type of coverage, Jan. 1, 1952*

Full coverage	Schedule coverage		No coverage
	Jurisdiction	Number of diseases [1]	
Alaska.	Alabama	[2]	Kansas.
Arkansas.	Arizona	36	Mississippi.
California.	Colorado	24	Oklahoma.
Connecticut.	Georgia	14	Wyoming.
Delaware.	Idaho	11	
District of Columbia.	Iowa	16	
Florida.	Kentucky	[3]	
Hawaii.	Louisiana	6	
Illinois.	Maine	14	
Indiana.	Montana	[4]	
Maryland.	New Hampshire	[5]	
Massachusetts.	New Mexico	31	
Michigan.	North Carolina	25	
Minnesota.	Pennsylvania	13	
Missouri.	Puerto Rico	17	
Nebraska.	South Dakota	25	
Nevada.	Tennessee	[6] 9	
New Jersey.	Texas	45	
New York.	Vermont	7	
North Dakota.			
Ohio.			
Oregon.			
Rhode Island.			
South Carolina.			
Utah.			
Virginia.			
Washington.			
West Virginia.			
Wisconsin.			
United States:			
Civil Employees.			
Longshoremen's Act.			

[1] In some States, the number of diseases refers to "groups of diseases."
[2] Covers pneumoconiosis, including silicosis, anthraco-tuberculosis, aluminosis, and other specified dust diseases.
[3] Covers only injury or death by gas or smoke in mines and poisonous gas in any occupation. Voluntary as to silicosis.
[4] Separate act provides for payment of $50 a month from public funds to persons totaley disabled from silicosis, if they have been State residents for 10 years.
[5] Covers silicosis and other pulmonary diseases, anthrax, lead poisoning, dermatitis venenata, and diseases due to the inhalation of poisonous gases or fumes.
[6] Full coverage permissible.

Source: Greene, Bruce A.: State workmen's Compensation Legislation in 1951. *Monthly Labor Review* 74:2 (January) 1952 and supplemental information.

Appendix 2.—*Labor union membership, United States, selected years, 1900–1950*

Year:	*Total union membership (thousands)*	Year:	*Total union membership (thousands)*
1900	791	1946	14, 974
1910	2, 116	1947	15, 414
1920	5, 034	1948	14, 000–16, 000
1930	3, 632	1949	14, 000–16, 000
1940	8, 944	1950	14, 000–16, 000
1945	14, 796		

Sources: U. S. Department of Commerce, Bureau of the Census: *Historical Statistics of the United States, 1789–1945, series 218–223.* Washington, U. S. Government Printing Office, 1949, p. 72; and Bureau of the Census: *Statistical Abstract of the United States, 1951.* Washington, U. S. Government Printing Office, 1951, p. 205.

Appendix 3.—*Percentage distribution of United States labor force, by occupational group, selected years, 1910–50*

Occupational group	1910	1920	1930	1940	1950
Total	100.0	100.0	100.0	100.0	100.0
Professional persons	4.4	5.0	6.1	6.5	7.5
Proprietors, managers, officials	23.0	22.3	19.9	17.8	16.3
Farmers (owners and tenants)	16.5	15.5	12.4	10.1	7.5
Except farmers	6.5	6.8	7.5	7.6	8.8
Clerks and kindred workers	10.2	13.8	16.3	17.2	20.2
Skilled workers and foremen	11.7	13.5	12.9	11.7	13.8
Semiskilled workers	14.7	16.1	16.4	21.0	22.4
Unskilled workers	36.0	29.4	28.4	25.9	19.8
Farm laborers	14.5	9.4	8.6	7.1	4.6
Laborers, except farm	14.7	14.6	12.9	10.7	7.8
Service workers	6.8	5.4	6.9	8.0	7.4

Source: U. S. Department of Labor, Bureau of Labor Statistics: *Selected Facts on Employment and Economic Status of Older Men and Women,* Washington, U. S. Government Printing Office, 1952, p. 11.

Appendix 4.—*National and international unions, United States, by affiliation and size of membership, January 1952* [1]

Number of members	All unions		Number affiliated with—		
	Number	Percent	AFL	CIO	Independent
Total	215	100.0	109	33	73
Under 1,000	23	10.7	10	----	13
1,000 and under 5,000	31	14.4	11	1	19
5,000 and under 10,000	23	10.7	6	4	13
10,000 and under 25,000	31	14.4	19	4	8
25,000 and under 50,000	32	14.9	20	5	7
50,000 and under 100,000	36	16.8	18	10	8
100,000 and under 200,000	17	7.9	12	3	2
200,000 and under 300,000	7	3.3	5	----	2
300,000 and under 400,000	7	3.3	3	4	----
400,000 and under 500,000	1	.5	1	----	----
500,000 and under 1,000,000	4	1.7	3	----	1
1,000,000 and under 1,200,000	3	1.4	1	2	----

[1] Includes at least 2 unions known by the Bureau to have been organized late in 1952. Although exact membership data are not available for all unions listed in this Directory, sufficient information is available to place all the unions within the groups in this table.

Source: U. S. Department of Labor, Bureau of Labor Statistics: *Directory of Labor Unions in the United States 1953, (Bulletin No. 1127),* Washington, U. S. Government Printing Office, 1953. p. 4.

Appendix 5.—*National and international unions, United States, by affiliation and number of locals, January 1952* [1]

Number of locals	All unions		Number affiliated with—		
	Number	Percent	AFL [2]	CIO	Independent
Total	212	100.0	109	33	70
Under 10 [3]	28	13.2	8	2	18
10 and under 25	22	10.4	5	----	17
25 and under 50	20	9.4	4	6	10
50 and under 100	33	15.6	18	5	10
100 and under 200	26	12.3	17	5	4
200 and under 300	18	8.5	11	7	----
300 and under 400	16	7.5	11	3	2
400 and under 500	6	2.8	5	----	1
500 and under 600	7	3.3	5	1	1
600 and under 700	3	1.4	3	----	----
700 and under 800	3	1.4	1	1	1
800 and under 900	8	3.8	7	1	----
900 and under 1,000	5	2.4	3	----	2
1,000 and under 1,500	8	3.8	5	1	2
1,500 and under 2,000	3	1.4	3	----	----
2,000 and over	6	2.8	3	1	2

[1] Although the exact number of locals is not available for all unions listed in this directory, sufficient information is available to place all but 3 independent unions within the indicated groups in this table. 1 of these independent unions was organized late in 1952.

[2] Includes 1 union organized late in 1952.

[3] Includes those unions which reported having no locals.

Source: U. S. Department of Labor, Bureau of Labor Statistics: *Directory of Labor Unions in the United States, 1953* (*Bulletin No. 1127*), Washington, U. S. Government Printing Office, 1953, p. 4.

Appendix 6.—*Distribution of reporting units with wages taxable under the old-age and survivors insurance program and of the estimated number of workers employed therein, by size of industry, March 1948*

Size of class (number of employees)	Reporting units [1]		Workers [2]	
	Number (in thousand)	Percent	Number (in thousands)	Percent
All units	2,734.2	100.00	35,805	100.00
1 to 49	2,637.9	96.48	14,219	39.71
50 to 499	88.9	3.25	11,085	30.96
500 to 999	4.4	.16	3,012	8.41
1,000 and over	3.0	.11	7,489	20.91

[1] A reporting unit is an establishment or a group of establishments of the same firm engaged in the same activity and located in the same area, generally the same county. Size of reporting unit is measured by the number of persons employed in the unit during the pay period ending nearest middle of March 1948.

[2] Represents estimated employment during pay period ending nearest middle of March 1948 for employers who reported taxable wages under the OASI program for January–March 1948.

Source: Klem, Margaret C., McKiever, Margaret F., and Lear, Walter J., M. D.: *Industrial Health and Medical Programs* (*P. H. S. Publication No. 15*). Washington, U. S. Government Printing Office, 1950, p. 38.

Appendix 7.—*Distribution of estimated employment in reporting units with wages taxable under the old-age and survivors insurance program, by industry and size of unit, March 1948* [1]

[Number in thousands]

Type of industry	Employment in reporting units of specified size [2]						
	All units	1–19	20–49	50–99	100–499	500–999	1,000 and over
Total	35,805	9,725	4,493	3,466	7,619	3,012	[3] 7,489
Agriculture, forestry, and fishing	70	47	12	6	6	0	0
Mining	955	123	100	95	295	162	181
Contract construction	2,030	862	367	251	381	98	72
Manufacturing	15,198	1,152	1,275	1,360	4,182	1,921	5,308
Public utilities	2,617	392	265	236	577	260	886
Wholesale trade	2,800	1,069	618	402	510	104	96
Retail trade	6,722	3,424	1,009	562	791	266	671
Finance, insurance, and real estate	1,741	672	252	174	354	100	189
Service industries	3,527	1,859	584	375	521	102	85
Not elsewhere classified	27	20	3	1	3	(4)	0
Unclassified	117	103	9	5	(4)	0	0
	[Percent distribution]						
Total	100	27.2	12.5	9.7	21.3	8.4	[3] 20.9
Agriculture, forestry, and fishing	100	66.2	16.9	8.5	8.5	0	0
Mining	100	12.9	10.5	9.9	30.9	17.0	19.0
Contract construction	100	42.4	18.1	12.4	18.8	4.8	3.5
Manufacturing	100	7.6	8.4	8.9	27.5	12.6	34.9
Public utilities	100	15.0	10.1	9.0	22.1	9.9	33.9
Wholesale trade	100	38.2	22.1	14.4	18.2	3.7	3.4
Retail trade	100	50.9	15.0	8.4	11.8	4.0	10.0
Finance, insurance, and real estate	100	38.6	14.5	10.0	20.3	5.7	10.9
Service industries	100	52.7	16.6	10.6	14.8	2.9	2.4
Not elsewhere classified	100	74.1	11.1	3.7	11.1	(4)	0
Unclassified	100	88.0	7.7	4.3	(4)	0	0

[1] Represents estimated employment during pay period ending nearest middle of March 1948 for employers who reported taxable wages under the OASI program for January–March 1948.

[2] A reporting unit is an establishment or a group of establishments of the same firm engaged in the same activity and located in the same area, generally the same county. Size of reporting unit is measured by the number of persons employed in the unit during the pay period ending nearest middle of March 1948.

[3] Includes 1,161,488 persons in 74 units, each employing 10,000 or more persons.

[4] Less than 1,000 persons.

Source: Klem, Margaret C., McKiever, Margaret F., and Lear, Walter J., M. D.: *Industrial Health and Medical Programs* (*P. H. S. Publication No. 15*), Washington, U. S. Government Printing Office, 1950. p. 41.

Appendix 8.—*Estimated number of persons eligible for hospital, surgical, and medical care through voluntary programs, by State and type of benefit, Dec. 31, 1952*

[In thousands]

State	Hospital	Surgical	Medical
United States, total	91,667	73,161	35,797
New England, total	6,594	5,008	3,408
Maine	509	273	132
New Hampshire	309	272	156
Vermont	258	212	107
Massachusetts	3,188	2,512	1,789
Rhode Island	655	503	381
Connecticut	1,675	1,236	843
Middle Atlantic, total	22,399	15,882	8,011
New York	11,296	8,505	3,958
New Jersey	3,136	2,265	1,503
Pennsylvania	7,967	5,112	2,550
East North Central, total	23,687	19,061	7,114
Ohio	6,611	4,358	1,055
Indiana	2,638	2,460	877
Illinois	6,831	5,162	1,968
Michigan	5,111	4,773	2,215
Wisconsin	2,496	2,308	999
West North Central, total	8,431	6,880	3,893
Minnesota	2,383	1,895	1,171
Iowa	1,317	1,086	589
Missouri	2,538	1,950	1,229
North Dakota	267	204	99
South Dakota	257	251	53
Nebraska	798	776	295
Kansas	871	718	457
South Atlantic, total	9,992	7,941	3,287
Delaware	229	212	204
Maryland	1,344	689	210
District of Columbia	838	623	145
Virginia	1,538	1,296	637
West Virginia	1,256	1,127	884
North Carolina	1,625	1,516	213
South Carolina	879	730	198
Georgia	1,205	924	252
Florida	1,078	824	544
East South Central, total	3,887	2,994	1,574
Kentucky	1,080	767	484
Tennessee	1,301	935	234
Alabama	993	890	560
Mississippi	513	402	296
West South Central, total	6,123	5,772	2,761
Arkansas	450	376	119
Louisiana	828	691	420
Oklahoma	1,045	1,008	479
Texas	3,800	3,697	1,743
Mountain, total	2,599	2,145	1,162
Montana	357	269	150
Idaho	270	190	100
Wyoming	173	141	95
Colorado	854	697	491
New Mexico	231	231	111
Arizona	337	285	79
Utah	319	274	114
Nevada	58	58	22
Pacific, total	7,825	7,360	4,488
Washington	1,329	1,232	916
Oregon	761	732	525
California	5,735	5,396	3,047
Territories, total	130	118	99
Alaska	8	4	3
Hawaii	122	114	96

Source: Health Insurance Council, survey committee: *Accident and Health Coverage in the United States.* New York, The Council, 1953. (In press.)

Appendix 9.—*Estimated number of persons eligible for specific health and disability benefits through voluntary programs, by type of program, United States, Dec. 31, 1952* [1]

Type of program	Number of persons eligible for medical and hospital benefits (in thousands)		
	Hospital	Surgical	Medical
Total coverage	100,548	81,384	38,746
Deduction for estimated duplication	8,881	8,223	2,949
Estimated total persons eligible	91,667	73,161	35,797
Group insurance, total	29,455	29,621	10,157
Subscribers	12,982	13,639	5,388
Dependents	16,473	15,982	4,769
Individual insurance, total	22,254	19,196	5,118
Subscribers	10,090	7,710	2,411
Dependents	12,164	11,486	2,707
Blue Cross plans and plans sponsored by medical societies	43,475	27,773	18,321
Subscribers	18,237	11,733	7,832
Dependents	25,238	16,040	10,489
Independent plans, total	5,364	4,794	5,150
Industrial	3,630	3,450	3,246
Community	617	316	303
Consumer	312	308	281
Private group clinics	405	420	420
University health plans	400	300	900

	Number of persons eligible for disability benefits (in thousands)
Total coverage	40,664
Deduction for estimated duplication	2,587
Estimated total persons insured	38,077
Group insurance	17,627
Individual insurance	12,937
Paid sick leave:	
In private industry	3,600
In civilian government service	4,600
Employee mutual benefit associations	900
Union plans and other employer-employee methods	1,000

[1] Since the purpose of this survey is to measure the extent and growth of coverage under employer-employee and other voluntary programs, individuals covered solely by Government insurance under compulsory plans have not been included in the total number of persons protected against loss of income due to disability. Also omitted from the survey are the following types of protection: Workmen's compensation providing protection to the majority of wage earners against occupational accidents and diseases; total and permanent disability benefits included in many life insurance policies; commercial accident policies providing disability indemnity and other benefits in event of accidental injuries; group accidental death and dismemberment insurance; commercial accident policies covering travel hazard; complete medical care for persons in the Armed Forces; complete medical care for persons in public institutions; medical care and disability pensions available under certain conditions to war veterans; protection under automobile and all other types of personal injury liability policies; and medical payment provisions under many automobile, residence liability, and other types of liability policies.

Source: The Survey Committee of the Health Insurance Council: *A Survey of Accident and Health Coverage in the United States.* New York, The Council, 1953. (In press.)

Appendix 10.—*Workers covered by employee-benefit plans under collective-bargaining agreements, by type of benefit and union affiliation, mid-1950* [1]

Type of plan	Total covered		Major union affiliation					
			AFL		CIO		Unaffiliated	
	Workers (thousands)	Percent	Workers (thousands)	Percent	Workers (thousands)	Percent	Workers (thousands)	Percent
Total	7,652	100.0	2,683	100.0	3,631	100.0	1,338	100.0
Health and welfare [2] and pension combined	4,599	60.1	884	32.9	2,830	78.0	885	66.1
Health and welfare	2,529	33.1	1,364	50.9	749	20.6	416	31.1
Pension or retirement	524	6.8	435	16.2	52	1.4	37	2.8

[1] Data based on information for 71 AFL unions, 29 CIO unions, and 31 unaffiliated unions. Also includes scattered AFL Federal labor unions and CIO local industrial unions and unaffiliated unions confined to a single plant or establishment.

[2] Includes 1 or more of the following types of benefits: life insurance or death; accidental death and dismemberment; accident and sickness (but not sick leave or workmen's compensation); cash or services covering hospital, surgical, maternity, and medical care.

Source: U. S. Department of Labor, Bureau of Labor Statistics: *Employee Benefit plans Under Collective Bargaining, Mid-1950* (*Bulletin No. 1017*). Washington, U. S. Government Printing Office, 1951. 7 pp.

Appendix 11.—*Distribution of 9,000 labor-management agreements and workers covered, by size of agreement coverage, 1950*

Agreement coverage	Agreements with employment data available		Workers covered	
	Number	Percent	Number	Percent
Total	9,157	100.0	7,180,000	100.0
1 to 24 workers	1,272	13.9	15,000	.2
25 to 49 workers	966	10.5	34,000	.5
50 to 99 workers	1,331	14.5	92,000	1.3
100 to 199 workers	1,611	17.6	223,000	3.1
200 to 299 workers	901	9.8	214,000	3.0
300 to 399 workers	617	6.7	204,000	2.8
400 to 499 workers	417	4.6	179,000	2.5
500 to 999 workers	973	10.6	651,000	9.1
1,000 to 1,999 workers	575	6.3	770,000	10.7
2,000 to 2,999 workers	166	1.8	389,000	5.4
3,000 to 3,999 workers	101	1.1	331,000	4.6
4,000 to 4,999 workers	51	.6	248,000	3.5
5,000 to 9,999 workers	85	.9	595,000	8.3
10,000 to 19,999 workers	55	.6	800,000	11.1
20,000 to 49,999 workers	25	.3	942,000	13.1
50,000 to 99,999 workers	6	.1	474,000	6.6
100,000 and over	5	.1	1,019,000	14.2

Source: Bortz, Nelson M. and Moros, Alexander: Characteristics of 12,000 Labor-Management Contracts, *Monthly Labor Review*, 73:34 (July) 1951.

Appendix 12.—*Workers eligible for health and welfare benefits under collective bargaining agreements, by major industry group and method of financing benefits, mid-1950* [1]

Industry group	Workers eligible for health and welfare benefits and/or pensions	Health and welfare benefits [3]			
		Workers eligible	Distribution of workers by method of financing benefits		
			Total	Employer only	Jointly financed	Undetermined
Total	[2] 7,652	7,128	100.0	54.6	36.5	8.9
Food and tobacco	205	195	100.0	74.9	21.0	4.1
Textile, apparel, and leather	1,401	1,401	100.0	90.5	2.6	6.9
Lumber and furniture	102	102	100.0	81.4	14.7	3.9
Paper and allied products	191	158	100.0	23.4	72.2	4.4
Printing and publishing	63	63	100.0	84.8	14.3	[4]
Petroleum, chemicals, and rubber	460	430	100.0	20.9	73.3	5.8
Metal products	2,481	2,324	100.0	15.1	72.2	12.7
Stone, clay, and glass	128	124	100.0	31.5	68.2	[4]
Mining and quarrying	492	492	100.0	96.3	3.1	[4]
Transportation, communications and other public utilities [5]	1,389	1,248	100.0	70.5	16.9	12.6
Trade, finance, insurance, and services	299	294	100.0	81.0	11.2	7.8
Unclassified	441	297	100.0	77.8	15.8	6.4

[1] Data based on information for 71 AFL unions, 29 CIO unions and 31 unaffiliated unions. Also includes scattered AFL Federal labor unions and CIO local industrial unions and unaffiliated unions confined to a single plan or establishment.

[2] About 60 percent of these workers were eligible for health and welfare benefits and pensions, 33 percent for health and welfare benefits only, and 7 percent for pensions only.

[3] Includes 1 or more of the following types of benefits: life insurance or death; accidental death and dismemberment; accident and sickness (but not sick leave or workmen's compensation); cash or services covering hospital, surgical, maternity, and medical care.

[4] Less than 1 percent.

[5] Excludes railroads.

Source: U. S. Department of Labor, Bureau of Labor Statistics: *Employee-Benefit Plans Under Collective Bargaining, Mid-1950* (*Bulletin No. 1017*). Washington, U. S. Government Printing Office, 1951, pp. 2, 5.

Appendix 13.—*Percent of plant workers in establishments with formal provisions for health insurance, by industry division, in 40 major labor markets, September 1951–May 1952*

Area	All industries [1]	Manufacturing	Percent of plant workers employed in—			Services
			Public utilities*	Wholesale trade	Retail trade	
NEW ENGLAND						
Boston	75.5	84.1	77.8	52.4	69.7	54.1
Hartford	64.6	----	65.5	41.0	32.9	19.0
Providence	63.2	65.7	69.6	35.9	49.4	41.0
Worcester	71.6	76.0	76.1	67.0	48.7	36.5
MIDDLE ATLANTIC						
Albany-Schenectady-Troy	66.1	77.3	61.6	45.3	32.6	17.5
Allentown-Bethlehem-Easton	77.2	82.3	21.1	33.0	[2] 54.4	38.0
Buffalo	66.1	75.6	55.2	35.4	40.8	20.1
Newark-Jersey City	73.0	77.4	77.7	56.6	53.5	28.3
New York	67.6	69.9	75.4	50.0	[3] 62.0	57.2
Philadelphia	63.9	76.0	40.2	28.6	59.0	24.4
Pittsburgh	79.3	89.4	72.5	42.7	30.3	54.3
Rochester	44.4	48.7	67.0	35.4	[3] 15.4	19.5
Scranton	65.8	64.1	82.0	29.5	79.6	36.8
Trenton	67.5	74.9	71.2	25.1	30.2	26.8
SOUTH						
Atlanta	57.4	68.1	63.3	42.4	48.3	33.5
Birmingham	48.8	57.5	60.8	25.7	31.4	5.6
Houston	50.3	66.8	49.1	43.6	36.8	15.5
Jacksonville	41.2	45.3	43.3	15.9	50.3	37.0
Memphis	46.4	44.0	78.7	36.1	50.4	32.4
New Orleans	31.0	46.0	20.1	22.3	24.0	19.0
Norfolk-Portsmouth	58.3	72.0	53.1	39.6	55.9	7.9
Oklahoma City	31.7	48.2	24.2	42.8	19.9	14.7
Richmond	47.9	52.2	53.8	23.2	52.6	15.5
MIDDLE WEST						
Chicago	83.1	89.9	89.5	55.2	64.2	59.3
Cincinnati	55.9	63.3	72.5	31.1	([4])	20.3
Cleveland	70.1	81.8	40.0	41.7	([4])	24.5
Columbus	74.1	89.5	76.5	47.1	44.1	30.1
Detroit	82.1	90.6	74.8	63.6	47.6	38.1
Indianapolis	78.5	87.6	83.8	53.2	([4])	25.9
Kansas City	65.6	73.6	78.5	42.0	51.4	48.3
Louisville	68.9	81.3	50.3	49.3	48.8	23.4
Milwaukee	75.9	85.4	54.2	65.4	41.7	53.5
Minneapolis-St. Paul	64.0	71.9	65.1	42.8	55.1	46.9
St. Louis	79.4	86.3	96.2	55.7	([4])	[5] 33.7
FAR WEST						
Denver	31.7	24.6	63.0	38.1	26.8	17.1
Los Angeles	70.4	77.4	85.3	64.0	[6] 57.2	[7] 31.9
Phoenix	55.3	67.7	56.1	61.7	47.7	36.6
Salt Lake City	72.7	79.4	72.2	71.6	71.0	56.3
San Francisco-Oakland	60.5	64.5	58.6	51.0	55.1	58.4
Seattle	43.7	29.8	86.5	54.0	46.1	36.2

[1] Includes data for industries in addition to those shown separately. In most cases, the areas selected for study rank among the Nation's largest metropolitan areas. The combined population of the 40 areas exceeded 52 million persons, three-fifths of the aggregate population of the Nation's 168 metropolitan areas having a minimum population of 100,000 and a central city of at least 50,000 population. More than 10 million workers were employed in the industries studied and 28 States were represented. With the exception of a few areas, mostly in the South, a majority of the workers were covered by collective bargaining agreements. The study does not indicate the extent to which the various benefits reported upon are a part of these agreements.

[2] Excludes data for department and limited-price variety stores.

[3] Excludes data for limited-price variety stores.

[4] Although data could not be shown separately for retail trade due to the omission of a number of department and limited-price variety stores, the remainder of retail trade is appropriately represented in the data for "all industries."

[5] Excludes data for hotels.

[6] Excludes data for department stores.

[7] Excludes data for motion picture production; these data are included, however, in "all industries."

*Transportation (except railroads), communication, and other public utilities.

Note: Data include such types of insurance as accident and sickness, and medical and surgical care to which the employer contributes toward the premium cost; exclude hospitalization insurance and paid sick leave.

Source: U. S. Department of Labor, Bureau of Labor Statistics: *Wages and Related Benefits, 40 Labor markets 1951–52* (*Bulletin No. 1113*). Washington, U. S. Government Printing Office, 1952, p. 57.

Appendix 14.—*Percent of plant workers in establishments with formal provisions for hospitalization, by industry division, in 40 major labor markets, September 1951–May 1952*

Area	All industries [1]	Manufacturing	Percent of plant workers employed in—			Services
			Public utilities*	Wholesale trade	Retail trade	
NEW ENGLAND						
Boston	58.3	75.1	30.4	40.9	34.5	42.5
Hartford	67.1	80.3	50.8	49.3	18.6	26.6
Providence	68.6	73.9	26.3	56.9	52.8	47.4
Worcester	61.9	70.3	34.7	54.4	21.4	35.2
MIDDLE ATLANTIC						
Albany-Schenectady-Troy	66.1	79.7	25.4	43.8	35.1	18.8
Allentown-Bethlehem-Easton	73.5	79.4	21.1	17.9	[2] 34.3	38.4
Buffalo	61.6	72.7	27.2	36.3	36.7	23.0
Newark-Jersey City	62.3	67.0	42.0	41.9	58.5	37.0
New York	63.9	63.5	46.7	53.7	[3] 80.4	62.0
Philadelphia	46.6	59.3	11.6	25.7	36.0	16.9
Pittsburgh	69.6	84.0	23.8	22.9	17.8	37.5
Rochester	28.5	31.2	40.8	20.5	[3] 12.0	10.9
Scranton	59.8	59.0	40.5	22.8	81.8	59.9
Trenton	73.1	80.5	52.7	57.4	37.9	42.4
SOUTH						
Atlanta	65.6	77.8	50.9	60.3	59.6	45.6
Birmingham	57.0	73.1	29.6	25.7	28.9	13.4
Houston	59.5	72.9	38.7	64.5	55.3	41.9
Jacksonville	54.1	69.7	27.6	33.9	50.9	73.2
Memphis	43.0	44.7	34.5	49.1	49.6	18.8
New Orleans	32.6	40.9	21.5	43.1	29.7	21.8
Norfolk-Portsmouth	59.2	65.4	55.6	45.5	69.5	10.8
Oklahoma City	45.9	46.1	51.7	43.7	41.0	56.8
Richmond	29.4	29.4	51.0	30.5	21.3	20.7
MIDDLE WEST						
Chicago	72.2	79.4	45.1	52.5	63.3	59.6
Cincinnati	51.6	63.4	24.8	33.1	[4]	20.8
Cleveland	47.3	57.7	10.2	27.8	[4]	9.8
Columbus	65.2	83.0	53.7	45.6	28.7	31.0
Detroit	78.5	88.1	64.0	52.2	43.3	32.4
Indianapolis	70.6	81.0	54.9	56.3	[4]	24.9
Kansas City	55.0	65.4	56.2	41.2	35.7	49.2
Louisville	65.8	78.2	38.1	41.7	49.0	27.6
Milwaukee	72.8	83.1	31.6	63.4	42.7	52.4
Minneapolis-St. Paul	58.8	69.1	47.2	48.5	48.1	35.6
St. Louis	64.5	72.4	58.2	43.9	[4]	[5] 26.3
FAR WEST						
Denver	25.8	26.3	37.3	42.8	21.3	1.7
Los Angeles	65.1	75.1	52.9	60.0	[6] 58.9	[7] 27.9
Phoenix	56.9	70.0	49.1	63.5	54.0	36.6
Salt Lake City	68.2	80.5	50.6	68.6	66.2	56.3
San Francisco-Oakland	53.3	62.1	23.1	51.2	52.4	64.0
Seattle	22.3	13.0	54.7	29.5	17.4	26.8

[1] Includes data for industries in addition to those shown separately. In most cases, the areas selected for study rank among the Nation's largest metropolitan areas. The combined population of the 40 areas exceeded 52 million persons, three-fifths of the aggregate population of the Nation's 168 metropolitan areas having a minimum population of 100,000 and a central city of at least 50,000 population. More than 10 million workers were employed in the industries studied, and 28 States were represented. With the exception of a few areas, mostly in the South, a majority of the workers were covered by collective bargaining agreements. The study does not indicate the extent to which the various benefits reported upon are a part of these agreements.

[2] Excludes data for department and limited-price variety stores.

[3] Excludes data for limited-price variety stores.

[4] Although data could not be shown separately for retail trade due to the omission of a number of department and limited-price variety stores, the remainder of retail trade is appropriately represented in the data for "all industries."

[5] Excludes data for hotels.

[6] Excludes data for department stores.

[7] Excludes data for motion picture production; these data are included, however, in "all industries."

*Transportation (except railroads), communication, and other public utilities.

Source: U. S. Department of Labor, Bureau of Labor Statistics: *Wages and Related Benefits, 40 Labor Markets 1951–52.* (*Bulletin No. 1113*). Washington, U. S. Government Printing Office, 1952, p. 58.

Appendix 15.—*Percent of plant workers in establishments with formal provisions for paid sick leave after 1 year of service, by industry division, in 40 major labor markets, September 1951–May 1952*

Area	All industries [1]	Manufacturing	Percent of plant workers employed in—			Services
			Public utilities*	Wholesale trade	Retail trade	
NEW ENGLAND						
Boston	8.6	1.5	28.8	29.3	7.7	14.3
Hartford	6.8	1.5	1.0	17.6	34.1	9.1
Providence	6.2	1.3	19.5	9.3	38.0	11.6
Worcester	3.4	----	3.5	7.5	25.1	12.3
MIDDLE ATLANTIC						
Albany-Schenectady-Troy	7.7	4.5	----	37.8	17.5	14.6
Allentown-Bethlehem-Easton	2.7	.1	36.7	17.7	[2] 17.3	8.4
Buffalo	7.5	2.1	29.3	24.7	21.2	5.1
Newark-Jersey City	7.9	5.7	2.2	12.8	34.4	14.8
New York	18.3	12.0	16.6	45.3	[3] 30.3	17.3
Philadelphia	6.4	2.9	16.5	9.2	11.4	11.9
Pittsburgh	8.1	.7	67.2	5.8	26.2	6.6
Rochester	7.2	1.5	33.8	21.8	[3] 27.6	14.8
Scranton	6.2	1.0	----	----	34.5	23.7
Trenton	2.2	1.0	----	10.2	13.6	----
SOUTH						
Atlanta	19.1	15.3	39.8	27.4	14.1	15.1
Birmingham	6.8	2.4	19.6	6.5	20.8	4.0
Houston	18.6	23.0	22.6	19.7	9.0	6.8
Jacksonville	12.8	3.6	----	11.9	33.4	----
Memphis	14.8	5.0	9.0	16.6	39.2	16.7
New Orleans	11.9	10.8	4.2	21.2	15.9	19.5
Norfolk-Portsmouth	8.5	4.1	10.0	2.6	17.5	12.7
Oklahoma City	11.7	1.5	25.2	26.0	12.3	7.0
Richmond	6.3	----	4.3	6.4	21.6	10.5
MIDDLE WEST						
Chicago	7.4	4.7	18.8	16.3	6.8	12.2
Cincinnati	3.9	1.0	1.3	20.0	([4])	4.1
Cleveland	4.4	.5	19.8	17.8	([4])	3.7
Columbus	15.2	21.3	14.9	13.4	.5	5.3
Detroit	9.1	3.1	30.4	23.0	39.5	11.1
Indianapolis	5.7	.6	22.0	14.6	([4])	11.7
Kansas City	6.1	4.1	14.6	13.9	4.3	7.9
Louisville	3.7	2.0	1.0	4.9	13.6	----
Milwaukee	8.4	2.6	7.0	38.9	32.2	8.5
Minneapolis-St. Paul	16.9	8.5	28.2	20.2	31.7	19.5
St. Louis	8.7	5.2	16.4	42.9	([4])	[5] 2.7
FAR WEST						
Denver	15.1	4.3	31.1	28.4	19.8	2.3
Los Angeles	20.9	22.2	21.6	33.3	[6] 16.5	[7] 9.7
Phoenix	18.2	2.3	37.2	35.3	30.7	----
Salt Lake City	25.1	25.4	27.5	20.2	33.7	----
San Francisco-Oakland	26.9	16.7	70.1	25.0	23.1	17.8
Seattle	6.1	1.1	19.1	13.8	5.6	5.9

[1] Includes data for industries in addition to those shown separately. In most cases, the areas selected for study rank among the Nation's largest metropolitan areas. The combined population of the 40 areas exceeded 52 million persons, three-fifths of the aggregate population of the Nation's 168 metropolitan areas having a minimum population of 100,000 and a central city of at least 50,000 population. More than 10 million workers were employed in the industries studied, and 28 States were represented. With the exception of a few areas, mostly in the South, a majority of the workers were covered by collective bargaining agreements. The study does not indicate the extent to which the various benefits reported upon are a part of these agreements.

[2] Excludes data for department and limited-price variety stores.

[3] Excludes data for limited-price variety stores.

[4] Although data could not be shown separately for retail trade due to the omission of a number of department and limited-price variety stores, the remainder of retail trade is appropriately represented in the data for "All industries".

[5] Excludes data for hotels.

[6] Excludes data for department stores.

[7] Excludes data for motion picture production; these data are included, however, in "All industries."

*Transportation (except railroads), communication, and other public utilities.

Source: U. S. Department of Labor, Bureau of Labor Statistics: *Wages and Related Benefits, 40 Labor Markets 1951–1952 (Bulletin No. 1113)*. Washington, U. S. Government Printing Office, 1952, p. 54.

Appendix 16.—*Distribution of manufacturing industries according to the proportion of wage earners under union agreements, 1946*

80–100 percent	60–79 percent	40–59 percent	20–39 percent	1–19 percent
Agricultural equipment. Aircraft parts. Aluminum. Automobiles and parts. Breweries. Carpets and rugs, wool. Cement. Clocks and watches. Clothing, men's. Clothing, women's. Electrical machinery. Furs and fur garments. Glass and glassware. Leather tanning. Meat packing. Newspaper printing and publishing. Nonferrous metals and products, except those listed. Rayon yarn. Rubber. Shipbuilding. Steel, basic. Sugar.	Book and job printing and publishing. Coal products. Canning and preserving foods. Dyeing and finishing textiles. Gloves, leather. Machinery, except agricultural equipment and electrical machinery. Millinery and hats. Paper and pulp. Petroleum refining. Railroad equipment. Steel products. Tobacco. Woolen and worsted textiles.	Baking. Chemicals. excluding rayon yarn. Flour and other grain products. Furniture. Hosiery. Jewelry and silverware. Knit goods. Leather, luggage, handbags, novelties. Lumber. Paper products. Pottery, including chinaware. Shoes, cut stock and findings. Stone and clay products, except pottery.	Beverages, nonalcoholic. Confectionery products. Cotton textiles. Dairy products. Silk and rayon textiles.	None.

Source: U. S. Dept. of Labor, Bureau of Labor Statistics: *Extent of Collective Bargaining and Union Recognition* (*Bulletin No. 909*). Washington, Government Printing Office, 1946, p. 2.

Appendix 17.—*Distribution of nonmanufacturing industries according to the proportion of wage earners under union agreements, 1946*

80–100 percent	60–79 percent	40–59 percent	20–39 percent	1–19 percent
Actors and musicians. Airline pilots and mechanics. Buss and streetcar, local. Coal mining. Construction. Longshoring. Maritime. Metal mining. Motion-picture production. Railroads. Telegraph. Trucking, local and intercity.	Radio technicians. Theater—Stage hands, motion-picture operators.	Bus lines, intercity. Light and power. Newspaper offices. Telephone.	Barbershops. Building servicing and maintenance. Cleaning and dyeing. Crude petroleum and natural gas. Fishing. Hotels and restaurants. Laundries. Nonmetallic mining and quarrying. Taxicabs.	Agriculture.[1] Beauty shops. Clerical and professional excluding transportation, communication, theatres, and newspapers. Retail and wholesale trade.

[1] Less than 1 percent.

Based on U. S. Dept. of Labor, Bureau of Labor Statistics: *Extent of Collective Bargaining and Union Recognition* (*Bulletin No. 909*). Washington, Government Printing Office, 1946, p. 2.

Source: Randle, C. Wilson, *Collective Bargaining, Principles and Practices*, 1951, Cambridge, Mass., The Riverside Press, p. 130.

Appendix 18.—*Specific health and welfare benefits in collective bargaining agreements, by number of workers covered and method of financing, mid-1950*

Type of benefit	Number of unions reporting benefits [1]	Workers covered by specific benefit		Method of financing			
		Number [2] (thousands)	Percent of total workers covered by all health and welfare benefits in 140 reporting unions [3]	Employer only		Jointly financed	
				Workers (thousands)	Percent	Workers (thousands)	Percent
Life insurance or death benefit	139	4,150	95.6	2,780	67.0	1,370	33.0
Accidental death and dismemberment	101	1,983	45.7	1,395	70.4	588	29.6
Cash payments for loss of time resulting from temporary sickness and accident (excluding sick leave and workmen's compensation)	101	2,781	64.1	1,640	59.0	1,141	41.0
Hospitalization	110	3,461	79.8	2,245	64.9	1,216	35.1
Surgical and/or medical	101	3,140	72.4	2,245	71.5	895	28.5

[1] Data on specific benefit coverage were available for 140 unions, including 38 AFL, 17 CIO, and 20 unaffiliated unions. Also includes scattered AFL Federal labor unions and CIO local industrial unions and unaffiliated unions confined to a single plant or establishment.
[2] Figures not additive since many workers are covered by more than 1 type of benefit.
[3] These 140 unions reported slightly more than 4.3 million workers covered by their health and welfare plans.

Source: U. S. Department of Labor, Bureau of Labor Statistics: *Employee-Benefit Plans Under Collective Bargaining, Mid-1950* (*Bulletin No. 1017*). Washington, U. S. Government Printing Office, 1951, p. 7.

Appendix 19.—*Distribution of 67 corporations according to daily hospital benefit allowance in health insurance plans, 1953* [1]

Daily benefits in dollars	Number of corporations with specified allowance for—	
	Employees	Dependents
Total	67	67
Uniform amount:		
$5–$7.50 [2]	12	12
8–10	43	39
11–14	8	[3] 6
Pays cost of semiprivate room	2	2
Graduated amount:		
$7–$8	1	1
10–12	1	0
No dependent benefits	----	7

[1] Based on a study of health insurance plans in effect in 67 corporations—21 with over 10,000 employees and 30 with from 1,000 to 10,000 employees; 61 are in the manufacturing field. All plans are underwritten by insurance companies and 18 are incorporated in union agreements.
[2] 1 company offers a choice of 4 plans. The basic plan and 1 of the optional plans pay $7.50 for employees and dependents. The other optional plans pay $10 and $15 respectively for employees and dependents.
[3] Includes 1 plan paying $14 for wife and $10 for children.

Source: Forde, Lois E.: New Health Insurance Plans. *Management Record.* 15: 127–128 (April) 1953.

Appendix 20.—*Distribution of 67 corporations according to maximum duration of hospital benefit allowance in health insurance plans, 1953* [1]

Maximum duration of benefits for each disability	Number of corporations with specified benefits for—	
	Employees	Dependents
Total	67	67
30 days	1	1
31 days	35	32
31 days plus 120 days at ½ rate [2]	2	2
42 days	1	1
70 days	23	20
70 days plus 80 days at ½ rate	1	1
91 days plus 9 months at slightly over ⅓ rate	1	0
91 days plus 9 months at ½ rate for children; slightly over ⅓ rate for wife	0	1
120 days	2	2
$1,500 including miscellaneous charge	1	0
No benefits	0	7

[1] Based on a study of health insurance plans in effect in 67 corporations—21 with over 10,000 employees and 30 with from 1,000 to 10,000 employees; 61 are in the manufacturing field. All plans are underwritten by insurance companies and 18 are incorporated in union agreements.

[2] In 1 company, employees may choose any 1 of 3 other plans which pay benefits for 180 days.

Source: Forde, Lois E.: New Health Insurance Plans, *Management Record* 15: 127–128 (April) 1953.

Appendix 21.—*Distribution of 67 corporations according to incidental hospital expense allowance in health insurance plans, 1953* [1]

Incidental allowances (equivalent to specified number of times the daily benefits)	Number of corporations with specified allowances for—	
	Employees	Dependents
Total	67	67
3 in nonsurgical; 7 in surgical cases	1	1
5	5	4
Slightly under 7	0	1
7	1	1
Slightly under 10	1	1
10	18	13
Slightly over 10	1	1
Slightly over 13	1	1
Slightly over 14	1	1
15	13	12
20	7	9
25	1	0
Slightly under 30	1	0
30	1	2
31	1	1
33⅓	1	1
50	1	1
100	1	1
10, plus 75 percent of next $2,000	1	0
10, or 10 plus 75 percent of next 1,200 (employee has choice)	1	1
Slightly over 16, plus 75 percent of next $4,000	1	1
20, plus 75 percent of next $2,000	1	1
70, plus next $100 and 75 percent of next $1,900	1	1
Approximately 5, plus all charges above $150	1	1
$1,500 including room and board charges	1	0
Actual charges	4	4
No benefits	0	7

[1] Based on a study of health insurance plans in effect in 67 corporations—21 with over 10,000 employees and 30 with from 1,000 to 10,000 employees; 61 are in the manufacturing field. All plans are underwritten by insurance companies and 18 are incorporated in union agreements.

Source: Forde, Lois E.: New Health Insurance Plans, *Management Record.* 15:127–128 (April) 1953.

Appendix 22.—*Distribution of 67 corporations according to maximum surgical benefit allowance in health insurance plans, 1953* [1]

Maximum surgical benefit allowed	Number of corporations with specified benefits for—	
	Employees	Dependents
Total	67	67
$140	0	1
$150	16	13
$175	3	2
$200	27	22
$225	5	5
$240	4	3
$250	5	4
$300 [2]	5	5
No surgical benefits	2	12

[1] Based on a study of health insurance plans in effect in 67 corporations—21 with over 10,000 employees and 30 with from 1,000 to 10,000 employees; 61 are in the manufacturing field. All plans are underwritten by insurance companies and 18 are incorporated in union agreements.

[2] 1 plan pays the following benefit for employees and dependents if the fee is above the schedule maximum: 75 percent of the portion of the fee falling between 100 and 166⅔ percent of schedule maximum (100 and 200 percent for assistant district managers, 100 and 300 percent for district managers).

Source: Forde, Lois E.: New Health Insurance Plans, *Management Record.* 15:152, (April) 1953.

Appendix 23.—*Main provisions of 8 selected companywide hospital-surgical-medical plans, 4 entirely financed under collective-bargaining agreements and 4 jointly financed by employer and employee* [1]

Class of company, date of agreement, total number of employees	Eligibility requirements	Hospital benefits		Miscellaneous hospital expenses	Maximum surgical benefits	Medical expense benefits	Maternity benefits
		Amount	Days or maximum benefits				
Entirely financed under collective bargaining agreements:							
A metal and plastic products company,[2] June 1, 1952, 800.	Employees in bargaining unit.	$10.00	70	$300 plus $25 X-ray.	$200	None	None.
An automobile company,[2] Jan. 1, 1952, 14,000.	Employees with 1 month of service.	10.00	31	$150	225	do	$100 plus $150 obstetrical.
A communications company,[3] June 9, 1952, 44,000.	Employees with 60 days of service.	10.00	31	$100; $50 for emergency outpatient treatment.	200	$3 times days in hospital prior to operation.	$10 for 14 days plus $80 miscellaneous charges plus $135 obstetrical.
A carpet company,[4] June 1, 1952, 7,000.	Employees with 3 months of service.	8.00	31	$40	150	None	$150.
Jointly financed plans:							
A drug company, Sep. 1, 1952, 3,500.	Full-time employees with 3 months of service.	14.00	$420	$200	225	$5 per home or hospital visit, $3 per office visit, $25 X-ray and laboratory: $250 maximum $300 nursing care. $50 deductible on combined medical and nursing benefits.	$14 a day for 14 days plus $200 miscellaneous charges plus $225 obstetrical fee.
A machinery company,[5] July 1, 1952, 6,500.	Full-time employees immediately. Dependents after 3 months of service.	11.00	$770	$100	225	Inhospital, $3 times days of confinement prior to operation. $210 maximum.	$150.
A metal products company,[6] Jan. 1, 1953, 1,800.	Employees with 3 months of service.	7.00	31	$70	150	None	(7).
A glass company, July 1, 1952, 8,000.	All employees immediately	9.50	70	$100	200	do	$60 plus $100 obstetrical.

[1] Identical benefits for employee and dependent except as noted in footnote 7.

[2] Agreement with United Automobile, Aircraft and Agricultural Implement Workers, CIO.

[3] Agreement with International Brotherhood of Electrical Workers, AFL.

[4] Agreement with Textile Workers Union of America, CIO.

[5] In addition following catastrophe insurance provided where annual salary is $6,000 or more: 80 percent of expenses (70 percent for surgery and nursing care over $500). $300 deductible. $10,000 individual maximum; $5,000 more on proof of insurability. Monthly contributions of $1.63 for an employee only and $4.65 for family coverage.

[6] In addition provides up to $5,000 polio coverage for employee and dependents.

[7] Provides following maternity benefits for employee: $7 or $8 for 14 days plus $70 or $80 miscellaneous charges plus $100 obstetrical; for dependents: $70 or $80 plus $100 obstetrical.

Source: Forde, Lois E.: New Health Insurance Plans. *Management Record*, 15:153–155 (April) 1953.

Appendix 24.—*Major changes during 1950 and 1951 in benefits available to union groups through welfare funds, New York City building trades*

Asbestos Workers: Life insurance increases from $400 to $600 in 1951.

Bricklayers: Added accident and sickness benefits in accordance with the disability benefit law in 1950. Hospitalization and surgical insurance extended to dependents in June 1951.

Carpenters: Plan began July 1, 1950, with accident and sickness benefits. All other benefits put into effect May 1, 1951, except that hospitalization and surgical insurance were extended to dependents on January 1, 1952.

Cement Masons: In 1950, added accident and sickness benefits; added hospitalization insurance for dependents at $8 per day; increased medical insurance from $2 to $3 for office visits, from $3 to $4.50 for other visits, and from $150 to $225 in maximum.

Composition Roofers: Not reported for review as of January 1, 1950. Added hospitalization insurance for children of employees on August 1, 1951.

Concrete Workers: In 1950, increased life insurance from $750 to $1,000; increased accident and sickness benefits from $15 a week to $30 a week. Added hospitalization and surgical insurance in November 1951.

Derrickmen: Benefit plan first put into effect on September 1, 1951.

Electrical Workers: January 1, 1951, added dental center furnishing free services and dentures at cost; January 1, 1952, increased hospitalization payment for employees to $10 for the first 10 days.

Engineers, Operating: Benefit plan began July 1, 1950, with accident and sickness insurance. Life-insurance and accidental-death and dismemberment insurance added in January 1951. Hospitalization insurance added on September 1, 1951.

Excavators: Benefit plan began July 1, 1950, with accident and sickness benefits. Other benefits added on July 1, 1951.

Glass Industry: In 1950, reduced accidental death and dismemberment insurance from $1,500 to $1,000; increased accident and sickness payments by fund from $20 a week to $21.33; increased hospitalization insurance from $6 a day to $9 a day, with increase in payment for extras from $30 to $90.

Hollow Metal Door: Benefit plan began on July 1, 1950, with accident and sickness insurance. All other benefits added on May 1, 1951, except that hospitalization and surgical insurance were extended to dependents on January 1, 1952.

Iron Workers 40 and 361: In 1950, changed accident and sickness benefit scale to 50 percent of wages up to minimum of $26; increased employee surgical insurance from $225 to $300; added $200 surgical insurance for dependents.

Iron Workers 455: On January 1, 1951, life insurance increased from $1,000 to $1,500; accidental death and dismemberment insurance increased from $1,000 to $1,500; hospitalization insurance increased from $6 a day to $8 a day and payment for extras from $60 to $80; surgical insurance increased from $150 to $200 and extended to dependents. Effective January 1, 1952, accident and sickness benefits increased from $30 to $35 maximum; hospitalization insurance increased from $8 to $10 a day (and $100, instead of $80, maximum for extras); surgical insurance was increased from $200 to $240.

Iron Workers 580: In 1950, life insurance increased from $1,000 to $2,000; accidental death and dismemberment insurance increased from $1,000 to $2,000; accident and sickness benefits increased from $20 to $26; hospitalization insurance increased from $6 daily benefit to Blue Cross.

Lathers, Metal: In 1950: added accident and sickness benefits. Extended surgical benefits to dependents, September 1, 1951.

Marble Industry: Added accident and sickness benefits in 1950.

Mason Tenders: No benefit changes.

Mosaic and Terrazzo: Medical insurance increased in 1951 from $3 per office visit and $4.50 from any other visit to $5 for all visits and maximum raised from $150 to $225 per disability.

Painting Industry: No benefit changes.

Plasterers: Increased surgical insurance from $150 to $200 effective August 1, 1951.

Plasterers' Helpers: Increased surgical insurance from $150 to $160 in 1950.

Plumbers, local 1: In 1951, increased surgical insurance from $210 to $300; increased maternity benefit from $75 to $100.

Plumbers, local 2: In 1950, life insurance increased from $500 to $1,000; accidental death and dismemberment insurance increased from $500 to $1,000; $100 hospital and $100 surgical benefit added for maternity benefit.

Riggers: Benefit plan first effective March 1, 1951.

Sheet Metal Workers: On August 1, 1951, changed surgical and medical benefits from Health Insurance Plan to $300 surgical insurance, medical insurance of $5 a visit, starting with the first visit (disability not required), and X-ray and laboratory benefits up to $100.

Slate Roofers: No benefit change.

Stone Setters: Benefit plan first effective September 1, 1951.

Source: Building Trades Employers' Association, committee on welfare funds: *A Review of Welfare Funds in the New York City Building Trades, January 1, 1952.* New York, The Association, 1952, pp. 4, 5, 6.

Appendix 25.—*Amount and duration of hospitalization insurance available to union groups through welfare funds, New York City building trades, Jan. 1, 1952*

Fund	Number of employees insured	Coverage	Daily rate	Maximum days	Reimbursement for extras	Maternity
Asbestos workers	570	Employees and dependents		Blue Cross [1]		Yes.
Bricklayers	8,800	Employees	$10	31	$60	No.
		Occupational	$7	31	$42	No.
		Dependents	$7	31	$35	Yes.
Carpenters	15,000	Employees and dependents	$10	31	$200	Yes.
Cement Masons	1,259	Employees	$10	31	$100	No.
		Dependents	$8	31	$80	Yes.
Composition Roofers	800	Employees and dependents	$6	31	$80	Yes.
Concrete Workers	4,605	do	$8	31	$80	Yes.
Derrickmen	139	Employees		Blue Cross [1]		Yes.
Electrical Workers	NA	Employees and dependents	$10 1st day; 10 days at $5.	105	None	Yes.
Engineers, Operating	3,000	do	$10	35	$300	Yes.
Excavators	2,500	None				
Glass Industry	669	Employees and dependents	$9	31	$90	Yes.
Hollow-Metal Door	1,200	do	$10	31	$200	No.
			$7	31	$140	Yes.
Ironworkers 40 and 361	1,300	do		Blue Cross [1]		Yes.
Ironworkers 455	3,100	do	$10	31	$100	Yes.
Ironworkers 580	800	do		Blue Cross [1]		Yes.
Lathers, Metal	2,315	do		do.[1]		Yes.
Marble Industry	594	Employees and wives	$10	31	$100	No.
Mason Tenders	8,300	None				
Mosaic and Terrazzo	400	Employees	$8	31	$40	No.
Painting Industry	5,276	Employees and dependents		Blue Cross [1]		Yes.
Plasterers	1,828	do		do.[1]		Yes.
Plasterers Helpers	971	Employees	$10	31	$150	No.
Plumbers, local 1	2,150	Employees and dependents	$10	31	$100	Yes.
Plumbers, local 2	3,700	do	$10	31	$85	$100.
Riggers	124	Employees	$8	31	$80	No.
Sheet Metal	2,200	Employees and dependents		Blue Cross [1]		Yes.
Slate Roofers	130	Employees	$6–$10	31	$60–$100	No.
Stonesetters	135	do		Blue Cross [1]		No.

[1] On Jan. 1, 1952, Associated Hospital Service, which provides Blue Cross coverage to New York City and surrounding areas, provided, each hospital admission, 21 days of full hospital service in a semiprivate room, including drugs, operating room, etc., and paid 50 percent of the charge for an additional 180 days.

Source: Building Trades Employers' Association, Committee on Welfare Funds: *A Review of Welfare Funds in the New York City Building Trades, January 1, 1952.* New York, The Association, 1952, p. 18.

Appendix 26.—*Amount and duration of life, accident, and sickness insurance available to union groups through welfare funds, New York City building trades, Jan. 1, 1952*

Funds	Number of employees insured	Life insurance	Accidental death and dismemberment insurance	Accident and sickness insurance		
				Day benefit begins: accident, sickness	Maximum weeks	Weekly benefit
Asbestos Workers	570	$600	None	(1)	(1)	(1)
Bricklayers	8,800	1,000	None	8; 8	13	50 percent of wages up to $26.
Carpenters	15,000	[2] 1,000	$1,000	8; 8	13	$26.
Cement Masons	1,259	500	500	1; 8	13	$26.
Composition Roofers	800	750	1,000	8; 8	13	$26.
Concrete Workers	4,605	1,000	None	1; 8	13	$30.
Derrickmen	139	1,000	1,000	1; 8	13	50 percent of wages up to $30.
Electrical Workers	NA	3,000	None	(3)	(3)	(3).
Engineers, Operating	3,000	1,000	1,000	1; 8	13	$40.
Excavators	2,500	750	750	8; 8	13	50 percent of wages up to $26.
Glass Industry	669	1,500	1,500	1; 8	13	$21.33.[4]
Hollow Metal Door	1,200	[2] 1,000	1,000	8; 8	13	50 percent of wages up to $26.
Iron Workers, 40 and 361	1,300	1,500	1,500	1; 8	13	Do.
Iron Workers, 455	3,100	1,500	1,500	1; 8	26	50 percent of wages up to $35.
Iron Workers, 580	800	2,000	2,000	1; 8	13	$26.
Lathers, Metal	2,315	1,500	1,500	1; 8	13	50 percent of wages up to $40.
Marble Industry	594	500	None	8; 8	26	$26.
Mason Tenders	8,300	1,000	None	1; 8	13	$26.
Mosaic and Terrazzo	400	500	1,000	1; 8	13	$26.
Painting Industry	5,276	1,000	1,000	1; 8	13	$10.
Plasterers	1,828	1,000	None	----------	None	
Plasterers' Helpers	971	1,000	1,000	----------	None	
Plumbers, local 1	2,150	150–500	None	----------	None	
Plumbers, local 2	3,700	1,000	1,500	----------	None	
Riggers	124	1,000	1,000	1; 8	13	60 percent of wages up to $30.
Sheet Metal	2,200	1,500	1,500	1; 8	13	Scale: $15–$50.
Slate Roofers	130	500–1,500	500–1,500	1; 8	13	Scale to $50.
Stonesetters	135	500	500	1; 8	13	50 percent of wages up to $30.

[1] Statutory benefits provided by employers, reimbursed by fund.
[2] $500 for unemployed and retired members.
[3] 2 weeks' full pay in case of occupational accident.
[4] $16 by insurance contract; total supplemented to $32 out of employee fund.

Source: Building Trades Employers' Association, Committee on Welfare Funds: *A Review of Welfare Funds in the New York City Building Trades, Jan. 1, 1952.* New York, The Association, 1952, p. 18.

Appendix 27.—*Amount and duration of medical and surgical benefits available to union groups through welfare funds, New York City building trades, Jan. 1, 1952*

Fund	Number of employees insured	Surgical insurance			Coverage	Medical insurance		Amount of benefits	Other
		Coverage	Maximum amount	Maternity		Type of visit covered	Visit benefits start		
Asbestos Workers	570	Employees and dependents.	$225	Yes	Employees and dependents.	Hospital and maternity.	1st day	1st day, $10 maximum; 2d day, $5 maximum; 6–21, $4 a day maximum.	Permanent disability, $20 a month.
Bricklayers	8,800	do	200	No	None				
			160	No					
Carpenters	15,000	do	200	No	Employees	Hospital	1st day	$4 a day, up to $200 per disability.	
			150	Yes					
Cement Masons	1,259	Employees	300	No	do	Any	1st, accident; 2d, sick.	$3 office; $4.50 other; maximum of $225 per illness or accident.	
Composition Roofers	800	do	100	No	None				X-rays, $20.
Concrete Workers	4,605	Employees and dependents.	200	Yes	do				X-rays and laboratory fees to $50.
Derrickmen	139	None							(1).
Electrical Workers	NA	Employees and dependents.	250	Yes					
Engineers, Operating	3,000	None							
Excavators	2,500	do							
Glass Industry	669	Employees	150						
Hollow Metal Door	1,200	Employees and dependents.	200	No	Employee	Hospital	1st day	$4 a day up to $200	
			150	Yes					
Iron Workers 40 and 361	1,300	do	300	No	None				
			200	Yes					
Iron Workers, 455	3,100	do	240	Yes	do				
Iron Workers, 580	800	Employees	(2)		Employee	Any	1st day	(2)	
Lathers, Metal	2,315	Employees and dependents.	250	Yes	None				
Marble Industry	594	Employees and wives	225	No	do				Polio coverage to $1,500.
Mason Tenders	8,300	None							
Mosaic and Terrazzo	400	Employees	150	No	Employees	Any	(3)		
Painting Industry	5,276	do	(2)		do	do	1st day	(2)	
Plasterers	1,828	do	200	No	None				
Plast. Helpers	971	do	160	No	do				

Plumbers, local 1	2,150	Employees and dependents.	300	$100	Employees and dependents.	Hospital	1st day	$16.50; 2–5, $8.25 a day; 6–21, $6.60 a day; 22–201, $3.30 a day.	
Plumbers, local 2	3,700	do	225	$100	Employee	Any	1st day	$3, office; $4, other; maximum of $200 in year.	Family X-ray and laboratory to $50.
Riggers	124	Employees	200	No	None				
Sheet Metal	2,200	do	300	No	Employee	do	1st day	$5 per visit, to $300 a year.	X-ray and laboratory for employee to $100.
Slate Roofers	130	do	150	No	None				
Stonesetters	135	do	200	No	do				

[1] Free service at dental center, including dentures at cost; care at rest home; medical care center authorized and in process of being built.

[2] Eligible for benefits under the Health Insurance Plan of Greater New York.

[3] 1st day, accident; $5 a visit; $225 maximum 8th, sick.

Source: Building Trades Employers' Association, Committee on Welfare Funds: *A Review of Welfare Funds in the New York City Building Trades, Jan. 1, 1952.* New York, The Association, 1952, p. 18.

Appendix 28.—*Benefits provided by the health and welfare plans of unions affiliated with the San Francisco Labor Council, May 1, 1952*

Type of benefit or coverage	Plans		Number covered	
	Number	Percent	Number	Percent
Total plans [1]	64	100	[3] 88,535	100
Life insurance	42	66	55,763	63
Accidental death and dismemberment	35	55	47,020	53
Health insurance [2]	64	100	88,535	100
Sick benefits in addition to State disability insurance	6	9	3,548	4
Plans incorporating payment for State disability insurance	14	22	27,785	31
Plans providing for dependent's coverage	54	84	67,270	76
Automatic coverage in basic plan	16	25	19,443	22
Voluntary coverage at employee's expense	38	59	47,827	54

[1] Plans providing more than 1 type of benefit are counted separately in each group applicable.
[2] Includes hospital, surgical, medical, and related health benefits.
[3] Represents about half of the council's membership.

Source: Weinerman, E. Richard: *The San Francisco Labor Council Survey: Labor Plans for Health.* San Francisco, The Council, 1952, p. 19.

Appendix 29.—*Basic questions to be considered in establishing hospitalization and medical care plans*

Is the company eligible? The only question that arises as to the eligibility of employers to inaugurate hospitalization and medical care plans concerns the number of employees. State statutes or regulations in almost all States regulate the minimum number that may be insured under a group policy by an insurance company. The minimum in the majority of States is 25. The minimum also must constitute 75 percent of the employees, or of the employees of a certain class. Companies that do not have enough regular employees to be eligible for group hospitalization and medical care insurance may secure a group policy jointly with other companies in the same industry. A joint group policy is usually negotiated through a trade association or through a union.

Although organizations especially incorporated to insure hospitalization and medical plans are usually exempt from the minimum requirement of the State insurance laws, Blue Cross and Blue Shield require the enrollment of a minimum number in a group. The enrolled group must also constitute a certain percentage of the total number of employees, or of a particular class of employees. The required percentage decreases in inverse ratio to the number of employees. Thus, a company with 10 employees may join some Blue Cross plans and Blue Shield plans if it secures 100 percent enrollment, whereas an employer with 1,000 need enroll only 40 percent.

What employees shall be eligible? In working out the details of a plan, an employer must consider the conditions of eligibility for participation that he wishes to impose, as well as those imposed by the insurance carrier.

When the employer pays the entire cost of the insurance, all employees, or all employees of a particular class, must be allowed to participate after the required waiting period. "Class of employees" means a group of employees having one or more common characteristics, such as salaried employees, clerical employees, employees in a particular wage bracket, or employees in a particular plant or division. If the employee contributes to the plan, the minimum percentage required by the insurance carrier must join. The percentage may be based on the number of employees in a particular class, instead of the total number of employees.

Other factors to consider in determining eligibility are these:

Service.—Under almost all hospitalization and medical plans, except excess medical care plans, all full-time employees at the time the plan is inaugurated

are eligible. New employees usually become eligible after they have completed a certain period of continuous employment. The usual requirement is 3 months.

Physical condition.—Physical examination is seldom required in group enrollments if the employee enrolls as soon as he is eligible. Many insurance carriers require examination and a sworn statement about the physical condition of dependents if the employee delays enrollment.

Union membership.—Some plans, particularly those administered by the union, or jointly by the union and employer, require union membership as a condition of participation.

Income.—Some insurance underwriters impose an income limit as a condition of eligibility.

Shall dependents be allowed to participate?—Under many plans financed entirely by the employer, dependents are not eligible. Under others, the employee may secure coverage for his dependents by paying the additional cost. If the employee contributes to the cost of the plan, coverage of dependents is usually optional with him . . .

What amount of benefits shall be offered?—The benefits provided by hospitalization and medical care plans affect the cost materially. The employer must consider carefully the benefits to be derived in relation to the cost of the plan, both to himself and to his employee.

As there is only one Blue Cross Plan available for each area, the employer has no decision to make if he decides that the local Blue Cross Plan offers more than a group insurance policy. On the other hand, under a group hospital expense insurance policy, premiums are in direct ratio to benefits. If the employer decides that an insurance company offers more than Blue Cross, he must then determine the minimum amount of benefits that are adequate to assure the success of hospitalization program for his employees.

With reference to a medical care plan, the employer must first decide whether he wants a surgical expense plan only, or a surgical and nonsurgical expense plan. He must then determine whether the nonsurgical care shall cover a physician's visit to the insured's home and visits by the patient to a physician's office, or be limited to inhospital cases, that is, a physician's visits in the hospital. Of course, the greater the scope of care, the higher the premium. If an employer chooses an insurance company to underwrite his plan, he limits the benefits according to the premium he and the employee can afford to pay.

An employer must also consider whether the amount of benefits is to be on a sliding scale in relation to salary and wage. This is not possible under Blue Cross and Blue Shield plans, nor under service plans underwritten by medical groups. . . .

The trend is away from a sliding scale of benefits that moves with the economic status of the employee. . . .

How should the plan be financed? Group hospitalization and medical care plans may be financed entirely by the employer, entirely by the employee, or jointly by the employer and the employees to be covered . . . Many insurance companies will not write a policy for a company that does not contribute; their experience has been that employer cooperation is related to contribution. Employer contribution is also a requirement of many community-sponsored plans. Some organiaztions underwriting plans require the employer to pay a certain percentage, usually 50 percent. Otherwise, each company bases its contributions upon its ability and willingness to contribute and upon the need of its employees for assistance. . . .

Under many contributory plans, the employer pays all the cost for the individual employee, and the employee pays the additional cost for dependents. Fre-

quently the employer will pay all the cost of group medical insurance if the employee will first subscribe to the hospitalization plan.

Many hospitalization and medical care plans that result from collective bargaining are financed entirely by contributions paid by the employer into a union trust fund, the fund providing the benefits. The cost may be a flat weekly, monthly, or annual amount for each covered worker; a stipulated contribution for each hour worked by the employee; a lump sum; or a percentage of the employer's payroll. See the Prentice-Hall Union Contract and Collective Bargaining Service for clauses from union contracts providing for contributory and noncontributory plans.

Source: Editorial staff of Prentice Hall, Inc.: *Successful Employees Benefit Plans.* New York, Prentice Hall, Inc., 1952, pp. 41–46.

Appendix 30.—*Factors that affect the cost of Blue Cross and Blue Shield Plans*

Blue Cross and Blue Shield Plans in each locality have a definite subscription rate. There are no factors that affect the cost to a particular group. The same is true of other local plans underwritten by medical groups or associations other than insurance companies. The service benefits provided by these plans are based upon current charges. If those charges are increased or decreased, the benefits change, and the subscription rates fluctuate with the changes. The following clause is included in a booklet describing a union-negotiated plan to the employees:

"The benefits provided in this part 2 are based upon current Blue Cross hospital charges. If those charges shall be increased for periods after January 31, 195–, it may be necessary for you to pay directly to the hospital some portion of the hospital's charge for daily bed and board in semiprivate accommodations or it may be necessary to change the benefits or your contributions under this part 2."

Several factors affect the cost of an insurance company's plan to a particular group. The benefits offered by the plan have a greater bearing on the cost than any other single factor. Obviously, the premium for a hospitalization plan that provides a daily benefit of $10 is considerably higher than the premium for a $5 daily benefit. Any special provision affects the cost proportionately. For example, if the age limit of a dependent is 21, instead of 18, the premium is higher.

The employer's special circumstances also affect the premium rate. In contracts other than Blue Cross and Blue Shield, a high percentage of female employees, or of non-Caucasian employees, may increase the premium. Usually the additional cost is borne by the employer, each employee contributing the same amount toward the premium. The average age of the employees also affects the premiums but not to the extent that it affects group disability or life insurance. Premiums are usually lower to employers that require physical examinations at the time of employment. In hospitalization and medical care plans that exclude occupational injuries and diseases, premiums for workers in hazardous jobs are not usually loaded. Although the premium rate rarely changes when hospitalization and medical charges decrease or increase, the cash indemnity constitutes a larger or smaller proportion of the total bill.

Each group covered by an insurance company is considered individually. If the claim experience in that group is favorable, the carrier returns part of the premium to the employer in the form of a dividend, or reduces the rate. Occasionally in plans negotiated by a union, the employer passes part of the dividend to the employee. Insurance company premiums rarely increase from year to year, even if the claim experience in a particular group is unfavorable. . . .

Source: Editorial staff of Prentice Hall, Inc.: *Successful Employee Benefit Plans.* New York, Prentice Hall, Inc., 1952, pp. 46–47.

Appendix 31.—*General principles and standards for approval of Blue Cross Plans, Blue Cross Commission of the American Hospital Association*

General principles

1. Approval as a Blue Cross Plan and use of the Blue Cross symbol and the words "Blue Cross" will be determined by a hospital service plan's adherence to the "Standards" set forth (under section III) of this program.

2. The interest and responsibility of contracting hospitals[1] make it desirable that in addition to representatives of the general public a substantial number of the plan's governing board be representatives of such hospitals. It is also desirable that the medical profession be represented on the plan's board.

3. All hospitals in each enrollment area that are qualified and equipped to provide the services in the plan's subscriber certificate should have an opportunity to contract to provide these benefits. At least a majority of these hospitals should so contract. Equitable arrangements should be made for provision of benefits in noncontracting hospitals.

4. No plan should be given original approval whose territory does not comprise sufficient area and population to provide adequate spread of risk and efficient and economical management, with an adequate number of hospitals to assure service to subscribers.

5. Plans should arrange for service benefits to members, rather than provide cash allowances for the purchase of hospital care.

Standards

1. Composition of the governing board: At least one-third of the members of a plan's governing board shall be representatives of the contracting hospital, and at least one-third shall be representatives of the general public.

2. Nonprofit sponsorship and control: Trustees or board members of a plan shall receive no remuneration for such service, nor shall any part of the net earnings of a plan inure to the benefit of any individual.

No plan shall accept working capital advanced on a basis which will place the contributors in a position to influence or direct its management because of the financial support. Working capital advanced shall be repayable out of earned income only, over and above operating expenses, payments to contracting hospitals, and legal reserves.

3. Extent of benefits: A plan shall cover on behalf of all subscriber patients who are enrolled under its most widely held certificate an average of not less than 75 percent of the total amount billed for usual and customary hospital services in the accomodations specified in the subscriber certificate for inpatients during the full coverage period. Total room and board charges to subscribers under certificates specifying only indemnity amounts for room and board shall be included in computing this average. What constitutes usual and customary hospital services shall be determined in accordance with local usage and custom in the area in which the plan operates and, in general, shall include all items on the hospital bill excepting fees of attending physicians, charges for private duty nurses, and charges for convenience items not directly related to patient care.

4. Financial responsibility: A plan shall maintain reserves adequate to protect hospital and subscribers' interests.

Adequate liability for (*a*) admissions reported but not yet paid, and (*b*) unreported admissions, shall be provided for and shall be shown in a plan's operating statement.

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[1] See footnote, p. 252.

A plan shall maintain an adequate reserve for contingencies over and above all liabilities. A plan's reserves, exclusive of liability items including (*a*) and (*b*) above, shall be sufficient at least to meet hospital and operating expenses for a period of 3 months.

A plan which does not meet this requirement, or which has not added at least 5 percent gross income to its contingency reserves during the preceding 12-month period, exclusive of liability items including (*a*) and (*b*) above, shall produce evidence satisfactory to the Blue Cross Commission and the board of trustees of the American Hospital Association that its financial policies are sound.

5. Responsibility for benefits to subscribers: A plan shall maintain written contractual agreements with a majority of the hospitals qualified and equipped to provide the services in the plan's subscribed certificate containing a majority of the bed capacity in its enrollment area, obligating the hospitals to furnish benefits to all subscribers enrolled at any given time. Such agreement shall provide for termination on not less than 90 days' notice.

Plan hospital contracts shall provide for payment by the plan for hospital care rendered its subscribers by such contracting hospital[1] in accordance with the contract, with no liability on the patient for benefits covered by his certificate.

6. Accounting and statistical records: A plan shall maintain such accounting and statistical records as may be reasonably required by the Blue Cross Commission, and shall submit such reports on the form and in the manner so prescribed.

7. Promotion and administration: No employee of a plan shall be paid principally by commission or on a production fee basis. An independent sales agency shall not be given responsibility for promotion or administration.

8. Interplan coordination: A plan shall participate in all national programs in which at least three-fourths of the plans representing also at least three-fourths of the weighted vote of all plans, as provided for in the administrative regulations, are participating, such as those relating to the transfer of members, the hospitalization of members in areas served by another plan, and uniform enrollment and billing procedures for employees of national firms. A plan which does not meet this requirement shall provide evidence satisfactory to the Blue Cross Commission and the board of trustees of the American Hospital Association that its participation in such national program would materially and inequitably affect its operation. Degree of participation in the application of this standard shall be determined separately for plans in Canada and in the United States.

9. It is expressly understood that, if any plan shall be unable to conform to any of the foregoing standards because of conflict with any law or governmental regulation binding on such plan, such standard shall not apply to such plan to the extent that such law or regulation shall prevent compliance therewith.

10. Failure to meet approval standards: If a plan fails to meet the provisions of one or more of the standards set forth under paragraphs 1 to 8, the Blue Cross Commission may recommend to the board of trustees of the American Hospital Association that such plan's right to employ the Blue Cross symbol and to use the words "Blue Cross" in identifying itself be withdrawn.

Source: Blue Cross Commission, American Hospital Association: *Blue Cross Approval Program of the American Hospital Association.* Chicago, The Association, 1952, pp. 8–12.

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[1] Wherever the words "contracting hospital" are used, it is the understanding of the board of trustees that a hospital guaranteeing service is meant.

Appendix 32.—*Standards of acceptance for medical care plans, council on medical service, American Medical Association*

The acceptance of a plan and the seal of the council are intended to signify that the plan conforms with or meets the following standards or requirements:

1. Local approval: The prepayment plan must have the approval of the state medical association or, if local, of the county medical society in whose area it operates. The State association or county society that sponsors the plan must retain the right to withdraw its approval and require discontinuance of the use of the seal of acceptance on reasonable notice to the public and to the underwriters.

2. Professional responsibility: The medical profession should assume responsibility for the medical services included in the benfits; the medical profession is qualified legally and by education to accept responsibility for the character of the medical services rendered.

(*a*) The plan should provide for the appointment of a committee by the medical profession in the area served by the plan. One of the duties of this committee shall be the determination of relative values of medical services and procedures as set forth in the plan's published schedule of benefits. The committee may also be authorized to consider difficulties and complaints and make recommendations.

(*b*) The published schedule of benefits of the plan shall include those services and procedures listed as essential by the council on medical service consistent with the scope of the plan.

3. Free choice of physician: There should be no regulation which restricts free choice of a qualified doctor of medicine in the locality covered by the plan who is willing to give service under the conditions established.

4. Patient-physician relationship: The method of giving the service must retain the personal, confidential relationship between the patient and physician.

5. Public policy: The plan should be organized and operated to provide the greatest possible benefits in medical care to the subscriber. Honesty of purpose and sincere consideration of mutual interests on the part of the subscribers, the physicians, and the plans are presupposed as necessary considerations for successful operation.

6. Type of benefits: Those benefits may be in terms of cash indemnity or medical service. Where benefits are paid in cash to the subscriber it must be clearly stated that those benefits are for the purpose of assisting in paying the charges incurred for medical service and do not necessarily cover the entire cost of medical service, except under specified conditions.

7. Clarity of benefits: Subscribers' contracts must state clearly the benefits and conditions under which benefits will be provided. All exclusions, waiting periods, and deductible provisions must be clearly indicated in the promotional literature and in the contracts.

8. Promotion: Promotional activities must be reasonable without extravagant or misleading statements concerning the benefits to the subscribers. In approving promotional material the council will endeavor to indicate the type of statements which are acceptable and the nature of those considered objectionable. It is not the function of the council to edit all copy word for word and sentence for sentence, but rather to indicate the general type of revision required in any given piece of literature. It expects the spirit and intent of such objections to be observed in the remainder of the copy not specifically criticized. Promotional activities will include any devices for informing the public or the profession.

9. Reports: Each accepted plan must agree to submit reports of financial and enrollment experience in the manner prescribed by the council.

10. Safeguards for the subscriber: The council will utilize the experience of those plans that are and have been operating successfully as a criterion for judging new plans, but will not discourage experiments in other types of coverage provided such experiments are limited in scope and capable of scientific evaluations. The following principles, however, are laid down as fundamental:

(*a*) The dues from subscribers through premium rates should be adequate to provide for the benefits offered and cover the risks involved.

(*b*) Enrollment practices shall be based on sound actuarial principles such as will not expose the plan to adverse selection. Group enrollment is recommended until experience warrants the acceptance of individuals.

(*c*) It is understood that the plan of organization will conform with State statutes and that the plan will operate on an insurance accounting basis with due consideration for earned and unearned premiums, administrative costs and reserves for contingencies, claims incurred but not paid, and unanticipated losses. Each plan must submit reports of financial experience in the manner prescribed by the council. Supervision should be under the appropriate State authority.

(*d*) Provision should be made for a medical director acceptable to the county or State medical society. The medical director may be paid on a per diem basis for the time involved in handling such matters.

(*e*) All insurance companies participating in the underwriting of a medical society prepayment plan must be licensed to do business in the State in which the plan is located. Inasmuch as the State insurance authorities supervise the finances and underwriting practices of such companies, the council will duplicate this function only to the extent it deems necessary.

11. Duration of acceptance: Acceptance of plans by the council will be for a period of 2 years (provided they comply with the standards during this period) or until revoked. At the end of this period all contracts and financial statements shall be reexamined. A shorter period of approval may be granted at the discretion of the council. Any changes in contracts or literature during the period of acceptance must be submitted to the council.

Source: Council on Medical Service, American Medical Association, *Voluntary Prepayment Medical Care Plans,* Chicago, 1952, pp. 145–147.

Appendix 33.—*Types of collective bargaining*

Industrywide bargaining: In its true sense, this term applies only to industrywide, countrywide bargaining. Four years, perhaps, the only group to which this term could be applied was the bituminous and the anthracite coal industry. . . . When loosely used, the term may cover the next type of bargaining.

Industrywide bargaining on an area basis: This term covers those cases in which bargaining is limited to all employers of an industry within a geographical area and to local unions within the industry in the same area. An outstanding example of this type of bargaining is the Pacific coast pulp and paper industry.

Areawide bargaining: This exists where all the employers within an area, irrespective of their industry, collectively bargain with all the unions within that same area. An example of this type of bargaining is the San Francisco Employers Council which bargains for its members with all unions within the city of San Francisco.

Association bargaining: This is the type of bargaining done by an employer association for its members, which are generally in a particular industry or craft within a city's limits. Such bargaining may cover tens of thousands of em-

ployees, as occurs when a city building employers' association bargains with an AFL building and construction trades council. Or it may cover a unit as small as a few hundred, such as when an embroidery employer association bargains with a local of the International Ladies' Garment Workers' Union, AFL. (Strictly speaking, association bargaining also covers almost all of the previous types of bargaining, as in most cases such bargaining does take place through an association; in practice, however, it is generally limited to bargaining for an industry or craft within a city's limits.)

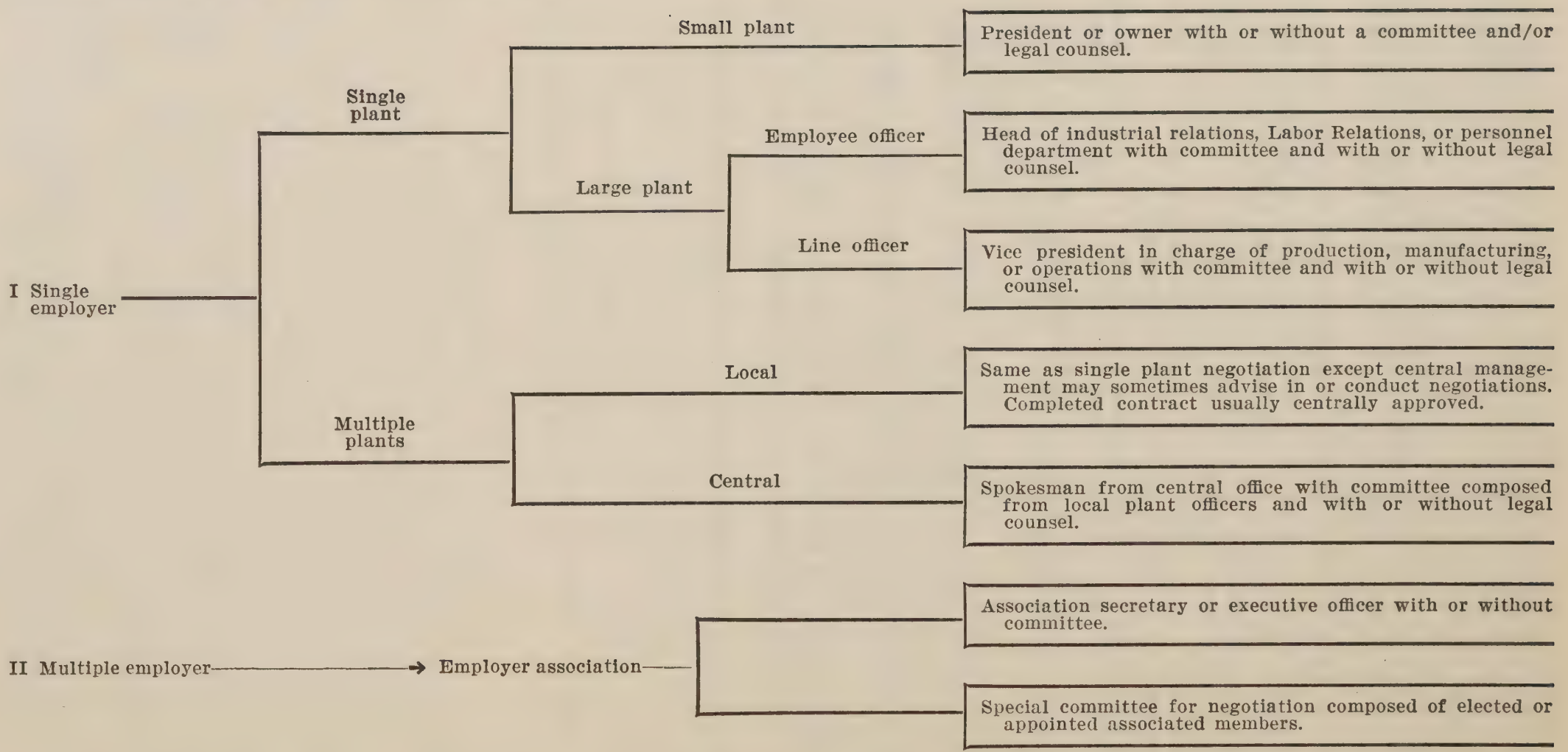
Companywide bargaining: This applies to a multiplant company that bargains at one time with all the various local unions of a national union that has unionized its plants. Such bargaining may come about as a result of company choice or through union pressure. The CIO Rubber Workers have secured companywide bargaining with some of the larger rubber companies. The CIO Oil Workers and Steelworkers are seeking this bargaining relationship in many firms which now deal with their local unions on a plant-by-plant basis.

Pattern bargaining: In this type, while one or more of the leading producers in an industry bargain with the union, the rest of the industry sits back and watches. The agreement reached by the leaders then becomes the basic outline for all contracts negotiated in the industry. Nominally there are many bargaining sessions at different times and places. But the union will rarely accept less than they receive from the leader, and the companies will rarely grant more. Segments of the textile industry, the rubber industry, and the glass manufacturers are engaged in this type of bargaining.

Local bargaining: This term covers bargaining between a single unit company and the local union representing its employees. More significantly, however, it covers bargaining between one unit of a multiunit company and the local union officials, and is therefore the antithesis to multiunit bargaining. In spite of the increasing trend toward larger bargaining units, local contracts are still most prevalent.

Source: Multiunit Bargaining—Introduction. *Management Record,* 14: 449–450 (December) 1952.

Appendix 34.—Employer structure for bargaining



Source: Randle, C. Wilson: *Collective Bargaining, Principles and Practices.* Cambridge, Mass., the Riverside Press, 1951, p. 159.

Appendix 35.—*Extent of multiemployer bargaining, 1947*

Industry	Number of production workers—1947 [1]	Production workers under union agreements, 1946 [2]	
		Percent	Percent covered by multiemployer agreements [3]
Grand total: Number of employees	18,232,800	*Range* 9,211,700–12,765,400	*Range* 4,700,000–8,589,000
INDUSTRYWIDE BARGAINING			
Subtotal: Number of employees	2,085,500	*Range* 1,593,900–2,011,100	*Range* 1,240,500–1,956,800
Coal mining:			
Bituminous	365,000	80–100	80–100
Anthracite	76,500	80–100	80–100
Elevator installation and repair	[4] 10,200	[4] 80–100	[4] 80–100
Glass and glassware	120,000	80–100	60–79
Installation of automatic sprinklers	[4] 13,000	[4] 80–100	[4] 80–100
Pottery (including chinaware)	56,100	40–59	60–79
Railroads [5]	1,352,000	80–100	[4] 80–100
Stoves	86,700	20–39	[4] 20–39
Wallpaper	[4] 6,000	[4] 80–100	[4] 80–100
REGIONWIDE BARGAINING			
Subtotal: Number of employees	3,485,300	*Range* 2,256,600–2,937,500	*Range* 1,084,000–1,955,300
Canning and preserving food [6]	199,500	60–79	60–79
Dyeing and finishing textiles [6]	84,500	60–79	60–79
Fishing	[4] 135,000	20–39	[4] 40–59
Hosiery	132,800	40–59	20–39
Intercity trucking	[4] 145,900	80–100	[4] 80–100
Leather tanning [6]	46,200	80–100	0–19
Longshoring [6]	[4] 985,000	80–100	80–100
Lumber [6]	650,000	40–59	20–39
Maritime	165,000	80–100	80–100
Metal mining	77,500	80–100	0–19
Nonferrous metals and products (excluding jewelry and silverware)	[6] 357,500	80–100	0–19
Paper and pulp	195,100	60–79	0–19
Shipbuilding	121,600	80–100	80–100
Shoes, boots, cut stock and findings [6]	19,400	40–59	20–39
Woolen and worsted textiles	170,300	60–79	0–19

See footnotes at end of table, p. 258.

Appendix 35.—*Extent of multiemployer bargaining, 1947*—Continued

CITY OR LOCAL AREA BARGAINING

Industry	Number of production workers—1947[1]	Production workers under union agreements, 1946[2]	
		Percent	Percent covered by multiemployer agreements[3]
Subtotal: Number of employees	12, 662, 000	*Range* 5, 359, 200–7, 816, 800	*Range* 2, 375, 500–4, 677, 800
Baking	216, 000	40–59	60–79
Beverages, nonalcoholic	32, 500	20–39	20–39
Book and job printing and publishing	177, 900	60–79	60–79
Breweries (malt liquors)	69, 600	80–100	[4] 80–100
Building service and maintenance	[4] 210, 000	20–39	40–59
Cleaning and dyeing	94, 600	20–39	[4] 80–100
Clothing, men's [7]	401, 000	80–100	80–100
Clothing, women's [7]	448, 500	80–100	80–100
Confectionery products	66, 700	20–39	0–19
Construction	1, 921, 000	80–100	60–79
Cotton textiles [7]	524, 300	20–39	0–19
Dairy products	85, 000	20–39	0–19
Fur and fur garments	[4] 25, 000	80–100	[4] 80–100
Furniture [7]	233, 100	40–59	0–19
Hotels and restaurants	[4] 918, 000	20–39	20–39
Jewelry and silverware	51, 500	40–59	20–39
Knit goods (excluding hosiery)	86, 800	40–59	[4] 0–19
Laundries	243, 000	20–39	80–100
Leather, luggage, handbags, etc	[4] 41, 600	40–59	[4] 40–59
Meat packing	181, 500	80–100	0–19
Millinery and hats	36, 400	60–79	[4] 40–59
Newspaper printing and publishing	141, 600	80–100	40–59
Paper products (excluding wallpaper)	188, 900	40–59	0–19
Silk and rayon textiles	104, 700	20–39	0–19
Steel products (excluding stoves)[7]	742, 800	60–79	0–19
Tobacco products	86, 000	60–79	0–19
Trade [7]	[4] 3, 584, 000	0–19	20–39
Trucking (local) and warehousing [7]	[4] 1, 750, 000	80–100	[4] 40–59

[1] U. S. Department of Labor, Bureau of Labor Statistics: *Employment and Payrolls, Detailed Report,* (February) 1948 (source unless where estimated).

[2] U. S. Department of Labor, Bureau of Labor Statistics: Extent of Collective Bargaining and Union Recognition, 1946. *Monthly Labor Review*, 44:766, (May) 1947 (source unless where estimated).

[3] *Ibid.*, Collective Bargaining with Associations and Groups of Employers, 44: 399 (March) 1947 (source unless where estimated).

[4] Estimated.

[5] Major issues are negotiated on an industrywide basis, but agreements continue to be signed by each railroad system.

[6] There is also some bargaining on a city, county, and/or metropolitan basis.

[7] There is also some bargaining on a regional and/or industrywide basis.

Source: Davey, Harold W.: *Contemporary Collective Bargaining.* New York, Prentice-Hall, Inc. 1951, pp. 57–59.

Appendix 36.—*Prevalence of insurance provisions in 503 union agreements, 1949–50*

Unions	Total number of contracts	Text of plan included in contract	Present plan continued and liberalized	Company agrees to adopt group insurance plan	Miscellaneous insurance clauses	No insurance clauses
Total unions	503	57	30	31	60	325
Percent	100.0	11.3	6.0	6.2	11.9	64.6
CIO Unions						
Auto workers	45	6	2	5	3	29
Brewery, flour, cereal workers	3	1				2
Electrical workers [1]	30	8	3	1	2	16
Food, tobacco, agricultural workers [2]	5				1	4
Gas, coke and chemical workers	10		2	1	1	6
Marine and shipbuilding workers	2	1				1
Mine, mill and smelter workers [2]	6	2	1			3
Newspaper guild	3	1				2
Office and professional workers [2]	4					4
Oil workers	17		2		7	8
Packinghouse workers	3	1		1	1	0
Paper workers	8		1	2	3	2
Playthings, jewelry, novelty workers	3		1		1	1
Rubber workers	12	2		1	3	6
Steelworkers	42	12	5	8		17
Textile workers	18	8		2		8
Transport workers	7		1		1	5
Utility workers	3		1		1	1
Other CIO unions	19	1	2		4	12
Total CIO unions	240	43	21	21	28	127
Percent	100.0	17.9	8.8	8.8	11.7	52.9
AFL Unions						
Airline pilots	2		1			1
Automobile workers	4				2	2
Bakery and confectionery workers	5	1				4
Cement, lime, gypsum workers	2					2
Chemical workers	10		1	1		8
Electrical workers	25	2		2	2	19
Engineers, International Union of Operating	4					4
Federal labor unions	15	2	1			12
Firemen and oilers	4					4
Grain millers	5				1	4
Meat cutters and butcher workmen	4					4
Molders and foundry workers	4					4
Office employees	14				4	10
Papermakers	16				2	14
Printing pressmen	2			1		1
Pulp, sulphite and paper mill workers	3				1	2
Retail clerks	4					4
Street, electric railway, and motor coach employees	6					6
Teamsters	5			1		4
Textile workers	5	1	2		1	1
Other AFL unions	23	1	1	3	3	15
Total AFL unions	162	7	6	8	16	125
Percent	100.0	4.3	3.7	4.9	9.9	77.2
Independent Unions						
Machinists, International Association of	32	3	1		8	20
Mine Workers, United	28	3		1	3	21
Other independent unions	41	1	2	1	5	32
Total independent unions	101	7	3	2	16	73
Percent	100.0	6.9	3.0	2.0	15.9	72.2

[1] Not certain whether local union involved is now affiliated with CIO through International Union of Electrical Workers or is now independent.
[2] Now independent.

Source: Brower, F. Beatrice: *Company Group Insurance Plans* (*Studies in Personnel Policy, No. 112*), New York, National Industrial Conference Board, 1951, p. 49.

Appendix 37.—*Group insurance provisions in 178 union agreements with insurance clauses, 1949–50*

	Total		CIO unions		AFL unions		Independent unions	
	Number of companies	Percent of companies	Number of companies	Percent of companies	Number of companies	Percent of companies	Number of companies	Percent of companies
Total	178	100.0	113	100.0	37	100.0	28	100.0
Text of plan in contract	57	32.0	43	38.0	7	18.9	7	25.0
Present plan to be liberalized	30	16.9	21	18.6	6	16.2	3	10.7
Company agrees to formulate plan	31	17.4	21	18.6	8	21.8	2	7.1
Present plan to be continued	33	18.5	18	15.9	6	16.2	9	32.1
Present plan to be made part of contract	3	1.7	3	2.7				
Union members may participate in existing plan	7	3.9	2	1.8	4	10.8	1	3.6
Plan prerogative of management	5	2.8					5	17.9
Company agrees to study plan	1	.6			1	2.7		
Provision for payment of premiums during layoff	2	1.1	1	.9	1	2.7		
Provision for military service	2	1.1			2	5.4		
Company to pay part of cost	3	1.7	1	.9	1	2.7	1	3.6
Life insurance for retired employees	1	.6	1	.9				
Company has group insurance plan	2	1.1	2	1.8				
Company to give notice of discontinuance	1	.6			1	2.7		

Source: Brower, F. Beatrice: *Company Group Insurance Plans* (*Studies in Personnel Policy, No. 112*). New York, National Industrial Conference Board, 1951, p. 50.

Appendix 38.—*Negotiated insurance programs: types of benefits included in 109 contracts with insurance clauses, 1949–50*

Types of benefits	Total contracts		CIO	AFL	Independent
	Number	Percent			
Contracts with insurance clauses	109	100.0	75	22	12
Benefits include:					
Life insurance	103	94.5	72	19	12
Accidental death and dismemberment benefits	44	40.4	30	9	5
Disability benefits	93	85.3	67	16	10
Hospital benefits, employees	70	64.2	50	12	8
Hospital benefits, dependents	31	28.4	23	5	3
Surgical benefits, employees	53	48.6	39	8	6
Surgical benefits, dependents	25	22.9	18	5	2
Medical benefits	19	17.4	16	2	1
Blue Cross	24	22.0	14	7	3
Blue Shield	5	4.6	2	2	1
Nonprofit medical	2	1.8	1	1	

Source: Brower, F. Beatrice: *Company Group Insurance Plans* (*Studies in Personnel Policy, No. 112*). New York, National Industrial Conference Board, 1951, p. 52.

Appendix 39.—*Employer contributions for social insurance and other labor income, 1929–52*

[In millions]

	1929	1930	1931	1932	1933	1934	1935	1936	1937	1938	1939	1940	1941
Total supplements to wages and salaries	$621	$621	$584	$542	$505	$547	$599	$921	$1,748	$1,935	$2,075	$2,199	$2,572
Employer contributions for social insurance	101	106	111	126	133	147	171	418	1,234	1,423	1,540	1,624	1,983
Old-age and survivors insurance									288	261	291	329	419
State unemployment insurance						3	7	159	588	780	815	813	1,011
Federal unemployment tax								81	89	102	105	98	124
Railroad retirement insurance									62	54	58	67	80
Railroad unemployment insurance											33	67	80
Federal civilian employee retirement systems	21	21	22	22	22	22	32	45	63	77	84	93	102
State and local employee retirement systems	72	78	84	96	107	118	127	131	141	147	152	155	165
Cash sickness compensation funds													
Government life insurance	8	7	5	8	4	4	5	2	3	2	2	2	2
Other labor income	520	515	473	416	372	400	428	503	514	512	535	575	589
Compensation for injuries	278	278	246	207	180	188	201	223	263	253	255	278	318
Employer contributions to private pension and welfare funds	128	124	121	113	103	123	129	169	139	145	156	170	183
Pay of military reservists	34	36	37	37	31	31	38	42	45	48	58	61	14
Other [1]	80	77	69	59	58	58	60	64	67	66	66	66	74

	1942	1943	1944	1945	1946	1947	1948	1949	1950	1951	1952
Total supplements to wages and salaries	$3,008	$3,565	$4,239	$5,353	$5,871	$5,929	$5,809	$6,559	$7,860	$9,081	$9,585
Employer contributions for social insurance	2,302	2,677	2,937	3,805	3,970	3,565	3,042	3,503	3,976	4,756	4,847
Old-age and survivors insurance	532	625	648	630	687	780	839	816	1,308	1,659	1,782
State unemployment insurance	1,089	1,246	1,177	1,011	893	1,029	965	1,010	1,217	1,465	1,351
Federal unemployment tax	161	183	184	174	184	212	228	223	232	263	275
Railroad retirement insurance	98	129	140	140	163	271	283	277	282	307	319
Railroad unemployment insurance	99	118	129	130	139	143	25	23	24	26	25
Federal civilian employee retirement systems	109	147	192	227	241	241	244	273	316	319	334
State and local employee retirement systems	185	202	212	225	250	290	360	420	510	570	620
Cash sickness compensation funds							0	2	7	3	3
Government life insurance	29	27	255	1,268	1,413	599	98	459	80	144	138
Other labor income	706	888	1,302	1,548	1,901	2,364	2,767	3,056	3,884	4,325	4,738
Compensation for injuries	367	403	443	478	495	560	614	643	676	804	885
Employer contributions to private pension and welfare funds	247	392	724	881	[2] 1,241	1,585	1,864	2,059	2,804	[2] 3,125	3,436
Pay of military reservists	3	2	1	5	27	125	188	244	284	273	283
Other [1]	89	91	134	184	138	94	101	110	120	123	134

[1] Consists of directors' fees, jury and witness fees, compensation of prison inmates, Government payments to enemy prisoners of war, marriage fees to justices of the peace, and merchant marine war-risk life and injury claims.

[2] First year that includes estimate for employer contributions for group insurance.

Source: U. S. Department of Commerce, Bureau of Foreign and Domestic Commerce: *National Income: 1951 Edition, a Supplement to the Survey of Current Business*, p. 201 and *Survey of Current Business*, July 1953, p. 24. Washington, U. S Government Printing Office.

Appendix 40.—*Percentage distribution of benefit payments for hospitalization and medical care by type of voluntary insurance plan, 1949–51*

Type of insurance carrier or plan	Percentage distribution of expenditures for benefits [1]								
	Total			Hospitalization [2]			Physicians [3]		
	1949	1950	1951	1949	1950	1951	1949	1950	1951
Benefit payments, total (millions)	$766.4	$991.9	$1,352.6	$538.6	$680.0	$896.8	$227.8	$311.9	$455.8
Percent	100.0	100.0	100 0	100.0	100.0	100.0	100.0	100.0	100.0
Blue Cross plans [4]	40.3	38.6	33.6	56.3	55.6	49.8	2.3	1.6	1.6
Physician-sponsored surgical plans	([5])	.4	.4	----------	----------	([5])	.2	1.2	1.1
Blue Shield plans	9.7	10.9	11.2	.8	.7	.6	30.8	33.0	32.0
Independent plans:									
Comprehensive industrial plans	4.5	3.5	2.8	2.7	2.2	1.8	8.6	6.4	4.8
Comprehensive nonindustrial plans	2.9	2.7	1.2	1.1	1.1	1.1	6.7	6.2	5.3
Limited hospitalization and surgical plans [6]	1.3	1.3	1.2	1.5	1.5	1.5	1.0	.9	0.8
Private group clinic prepayment plans	1.1	1.0	.9	.5	.4	.4	2.8	2.3	2.0
Commercial insurance: [4]									
Group	23.5	25.9	30.7	20.2	22.6	27.9	31.2	33.0	36.2
Individual	15.0	14.4	12.7	15.4	14.7	13.0	14.0	13.8	12.1
Bituminous-coal plans [4]	1.1	.8	3.7	1.1	.8	3.7	1.3	.9	3.7
Student health services [4]	.5	.4	.3	.3	.2	.2	1.1	.8	.5

[1] Benefits paid for nonprofit and other organizations; losses incurred for commercial insurance.
[2] Includes some expenditures for outpatient services.
[3] Includes some expenditures for services received other than those received from physicians (nurses, dentists, laboratories, etc).
[4] Allocation between hospital and medical care benefits among plans offering both is estimated.
[5] Less than 0.05 percent.
[6] Includes industrial plans with limited benefits.

Source:
Voluntary Insurance Against Sickness: 1950 Estimates. *Social Security Bulletin*, 14:20–23 (December) 1951.
Voluntary Insurance Against Sickness: 1951 Estimates. *Social Security Bulletin*, 15:3–7 (December) 1952.

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